

may be retained by the hospital or attending physician. **GENERAL DIRECTOR:** For this certificate has been signed by the attending physician on the sample filled in by the funeral director, page 3 should be detached prior to use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2913

CERTIFICATE OF DEATH

02874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 19 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3701.4			
3. NAME OF DECEASED (Type or print) First Jennie Middle Katherine Last Addison				4. DATE OF DEATH Month March Day 18 Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 2, 1885	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min.		11. IF UNDER 24 HRS. Months 75 Days 75 Hours 75 Min.		12. IF UNDER 24 HRS. Months 75 Days 75 Hours 75 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Nicholas Gross				14. MOTHER'S MAIDEN NAME Unknown Mary Eckert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unknown			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis, severe DUE TO (c) years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb. 29 , 19 60 , to March 18 , 19 60 , that I last saw the deceased alive on March 18 , 19 60 , and that death occurred at 1:20p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachsler				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL 3-18-60			
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/22/60			
22c. NAME OF CEMETERY OR CREMATORY London Park				22d. LOCATION (City, town, or county) (State) Balto. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE P. B. Wippest - 1300 E. 1st St. Ph.				24a. REC'D BY REGISTRAR DATE MAR 23 '60			
24b. REGISTRAR'S SIGNATURE Colbert S. Kraus							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2915 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02876

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 8yr4mth22dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland 1661.2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 5405 - 35th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eudora Middle Thomas Last Anderson				4. DATE OF DEATH Month Mar Day 19 Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 11, 1890	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Washington, D. C.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME David Anderson				14. MOTHER'S MAIDEN NAME Eudora Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure DUE TO Coronary disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. fracture left femur (b) fracture left femur (c) fracture left femur </div> <div style="width: 35%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH 904.7 </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) apparent with fracture							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) On 3-7-60 pt. was found unable to walk, complaining of pain in left leg. X-ray revealed comminuted intertrochanteric frac. of left femur.					
20c. TIME OF INJURY Hour ? a. m. 3 p. m. 7		Month, Day, Year 3 - 7 - 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital	
20f. (City or town) Catonsville		(County) 28, Md.		(State) Md.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE George M. Kieffer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) George M. Kieffer, M. D.				DATE SIGNED Mar 19 60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/22/60		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE MAR 22 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				24c. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

STATE OF MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____	
PLACE OF BIRTH _____		DATE OF BIRTH _____		TIME OF BIRTH _____	
OCCUPATION _____		CAUSE OF DEATH _____		MANNER OF DEATH _____	
PLACE OF DEATH _____		DATE OF DEATH _____		TIME OF DEATH _____	
SIGNATURE OF MEDICAL EXAMINER _____		SIGNATURE OF WITNESS _____		SIGNATURE OF DECEASED _____	
PRINTED NAME OF MEDICAL EXAMINER _____		PRINTED NAME OF WITNESS _____		PRINTED NAME OF DECEASED _____	
ADDRESS OF MEDICAL EXAMINER _____		ADDRESS OF WITNESS _____		ADDRESS OF DECEASED _____	
CITY OF MEDICAL EXAMINER _____		CITY OF WITNESS _____		CITY OF DECEASED _____	
STATE OF MEDICAL EXAMINER _____		STATE OF WITNESS _____		STATE OF DECEASED _____	
COUNTY OF MEDICAL EXAMINER _____		COUNTY OF WITNESS _____		COUNTY OF DECEASED _____	
ZIP CODE OF MEDICAL EXAMINER _____		ZIP CODE OF WITNESS _____		ZIP CODE OF DECEASED _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, pages 1 and 2 should be filled with the information required. The funeral director should use as the burial-transit permit. Then please remove carbon 3 and 4 from the certificate and return them to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2914

CERTIFICATE OF DEATH

02875

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines		d. STREET ADDRESS 3234 Clifton Ave.	
3. NAME OF DECEASED (Type or print) First MARIE Middle M. Last ANDERSEN		4. DATE OF DEATH Month Mar. Day 1, Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 24, 1876
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR: Months 1 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Norway		12. CITIZEN OF WHAT COUNTRY? unknown	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown Marum	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Nicholas Anderson - 3234 Clifton Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident (left) 443X DUE TO Bilateral Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis - Hypertensive C.V. DUE TO (c) Hypertensive C.V.		INTERVAL BETWEEN ONSET AND DEATH 1 month 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 22, 1960 , to March 1, 1960 , that I last saw the deceased alive on Feb. 29, 1960 , and that death occurred at 6:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Bernard J. Cohen		ADDRESS (Street, city or town, state) The Maryland Center, 3501 St. Paul - Balt. IF.	
PHYSICIAN'S NAME (Type) BERNARD J. COHEN.		DATE SIGNED Mar 7 '60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/60	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. F. Lickner & Sons - Balt. IF		24a. REC'D BY REGISTRAR Arthur S. Thomas	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		DATE MAR 7 '60	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. OCCUPATION		11. EDUCATION		12. MARITAL STATUS	
13. PREVIOUS ILLNESS		14. PRESENT ILLNESS		15. MEDICAL HISTORY	
16. PHYSICIAN'S SIGNATURE		17. CORONER'S SIGNATURE		18. REGISTRAR'S SIGNATURE	
19. DATE OF ENTRY		20. TIME OF ENTRY		21. PLACE OF ENTRY	
22. NAME OF HOSPITAL		23. NAME OF PHYSICIAN		24. NAME OF NURSE	
25. NAME OF CHURCH		26. NAME OF MINISTER		27. NAME OF DEACON	
28. NAME OF SUNDAY SCHOOL		29. NAME OF YOUTH LEADER		30. NAME OF YOUTH LEADER	
31. NAME OF YOUTH LEADER		32. NAME OF YOUTH LEADER		33. NAME OF YOUTH LEADER	
34. NAME OF YOUTH LEADER		35. NAME OF YOUTH LEADER		36. NAME OF YOUTH LEADER	
37. NAME OF YOUTH LEADER		38. NAME OF YOUTH LEADER		39. NAME OF YOUTH LEADER	
40. NAME OF YOUTH LEADER		41. NAME OF YOUTH LEADER		42. NAME OF YOUTH LEADER	
43. NAME OF YOUTH LEADER		44. NAME OF YOUTH LEADER		45. NAME OF YOUTH LEADER	
46. NAME OF YOUTH LEADER		47. NAME OF YOUTH LEADER		48. NAME OF YOUTH LEADER	
49. NAME OF YOUTH LEADER		50. NAME OF YOUTH LEADER		51. NAME OF YOUTH LEADER	
52. NAME OF YOUTH LEADER		53. NAME OF YOUTH LEADER		54. NAME OF YOUTH LEADER	
55. NAME OF YOUTH LEADER		56. NAME OF YOUTH LEADER		57. NAME OF YOUTH LEADER	
58. NAME OF YOUTH LEADER		59. NAME OF YOUTH LEADER		60. NAME OF YOUTH LEADER	
61. NAME OF YOUTH LEADER		62. NAME OF YOUTH LEADER		63. NAME OF YOUTH LEADER	
64. NAME OF YOUTH LEADER		65. NAME OF YOUTH LEADER		66. NAME OF YOUTH LEADER	
67. NAME OF YOUTH LEADER		68. NAME OF YOUTH LEADER		69. NAME OF YOUTH LEADER	
70. NAME OF YOUTH LEADER		71. NAME OF YOUTH LEADER		72. NAME OF YOUTH LEADER	
73. NAME OF YOUTH LEADER		74. NAME OF YOUTH LEADER		75. NAME OF YOUTH LEADER	
76. NAME OF YOUTH LEADER		77. NAME OF YOUTH LEADER		78. NAME OF YOUTH LEADER	
79. NAME OF YOUTH LEADER		80. NAME OF YOUTH LEADER		81. NAME OF YOUTH LEADER	
82. NAME OF YOUTH LEADER		83. NAME OF YOUTH LEADER		84. NAME OF YOUTH LEADER	
85. NAME OF YOUTH LEADER		86. NAME OF YOUTH LEADER		87. NAME OF YOUTH LEADER	
88. NAME OF YOUTH LEADER		89. NAME OF YOUTH LEADER		90. NAME OF YOUTH LEADER	
91. NAME OF YOUTH LEADER		92. NAME OF YOUTH LEADER		93. NAME OF YOUTH LEADER	
94. NAME OF YOUTH LEADER		95. NAME OF YOUTH LEADER		96. NAME OF YOUTH LEADER	
97. NAME OF YOUTH LEADER		98. NAME OF YOUTH LEADER		99. NAME OF YOUTH LEADER	
100. NAME OF YOUTH LEADER		101. NAME OF YOUTH LEADER		102. NAME OF YOUTH LEADER	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 10

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2910

Item 7 Film 6250 3/11/60 1wk

02877

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY a.a.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 25 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HOWARD Middle C. Last ANDREWS				4. DATE OF DEATH Month March Day 1 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 8, 1895		9. AGE (In years lost birthday) 64 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charles Andrews				14. MOTHER'S MAIDEN NAME Florence Danker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I/ 218-10-2791		17. INFORMANT Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL BRONCHOPNEUMONIA 491x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MALIGNANT MELANOMA OF THE RIGHT ARM WITH GENERALIZED METASTASES (c) UNKNOWN							INTERVAL BETWEEN ONSET AND DEATH 5 Days Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Baltimore	(State) Md.		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 5 19 60 , to March 1 19 60 , that 1x (we) last saw the deceased alive on March 1 19 60 , and that death occurred at 12:05 PM , from the causes and on the date stated above.							
22a. SIGNATURE Caridad E. Gonzalez NAME (Type) CARIDAD E. GONZALEZ, M.D.		22b. DATE 3/2/60		22c. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22d. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/4/60	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town, or county) Baltimore, Maryland		(State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE C. Vernon Lemmon		25a. REC'D BY REGISTRAR 4611 Park Hgts. Ave.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE MAR 7 '60	

may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and is valid for use as the burial-transit permit. Then please remove carbon parts. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03271

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2904

CERTIFICATE OF DEATH

02878

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. LENGTH OF STAY IN 1b 51	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1316 Francis Ave.		d. STREET ADDRESS 1316 Francis Ave.	
3. NAME OF DECEASED (Type or print) First IDA Middle ELIZABETH Last ARINGTON		4. DATE OF DEATH Month Mar. Day 7, Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1888
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse (rtd)		10b. KIND OF BUSINESS OR INDUSTRY self employed	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James E. Arington		14. MOTHER'S MAIDEN NAME Rachel Matilda Rasnik	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Edna Meinhardt - 1316 Francis Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Essential vascular hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchopneumonia (c)		INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 26, 1960 , to March 7, 1960 , that I last saw the deceased alive on March 7, 1960 , and that death occurred at 9:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1264 Francis Ave (37)			
ACTUAL SIGNATURE Charles R Shultz me		M.D. 1264 Francis Ave (37)	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/12/60	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto 17		24a. REC'D BY REGISTRAR MAR 9 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, the funeral director should use as the burial-transit permit. Then please remove carbon copies 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2917 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02879

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORTH BROOK</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7750 GOUGH ST. #24.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORTH BROOK</u> d. STREET ADDRESS <u>7750 GOUGH ST. #24.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>LESTER LOUIS AYERS</u>				4. DATE OF DEATH Month Day Year <u>MARCH 17, 1960</u>									
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 6, 1908</u>		9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE MAN REVERE BRASS</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BALTIMORE, MD.</u>				11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>					
13. FATHER'S NAME <u>JOHN AYERS</u>				14. MOTHER'S MAIDEN NAME <u>MISSOURI ROWLEY</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>EDNA AYERS</u>				17. INFORMANT Address <u>SAME.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CA of Bowel & Me Int.</u> <u>153.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Jack C. Collins</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>JACK C. COLLINS</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <u>3-17-60</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>3-21-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN CEM.</u>				22d. LOCATION (City, town, or county) (State) <u>7225 EASTERN BLVD. BALTO. CO., MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Charles S. Jelen 901 S. CONKLING ST. BALTO. 24 MD</u>										24a. REC'D BY REGISTRAR DATE <u>MAR 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by you for your files. The funeral director should be used as a burial-transit permit. File pages 1 and 2 in the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2918

CERTIFICATE OF DEATH

Reg. Dist. No.

02880

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere		c. LENGTH OF STAY IN 1b 35 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Res., 2407 Estelle Avenue		e. STREET ADDRESS 2407 Estelle Avenue	
3. NAME OF DECEASED (Type or print) Viola L. Baker		4. DATE OF DEATH March 17, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 6, 1894
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Assembly Work		10b. KIND OF BUSINESS OR INDUSTRY Rheem Mfg. Co.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gaston		14. MOTHER'S MAIDEN NAME Irene Fyock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-03-4982	
17. INFORMANT Mr. Doyle Kelly		Address 1928 Cedar Lane 22, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X DUE TO Generalized Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Cervix DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 mos. 3 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1957 to Mar. 17, 1960 , that I last saw the deceased alive on Mar. 16, 1960 , and that death occurred at 11 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James T. Means		ADDRESS (Street, city or town, state) 520 S. St. Balt. Md DATE SIGNED 3-18-60	
PHYSICIAN'S NAME (Type) James T. Means			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 21, 60	22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial	22d. LOCATION (City, town, or county) (State) Taylor Ave. Md.
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA		ADDRESS 7922 Wise Ave. 22, Md.	
24a. REC'D BY REGISTRAR MAR 21 60		24b. REGISTRAR'S SIGNATURE Walter S. Hanna	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached and used as the burial-transit permit. Then please remove carbon 1 and 2 should be kept with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Call 504-1234

Page 1

DATE OF DEATH

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CAUSE OF DEATH

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02882

VS A15 (4)
ISM 9/5B

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Rockdale</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rockdale, Baltimore 7, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>3502 St. James Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>A.</u> Last <u>Baumann</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 2, 1887</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor & Furrier</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>Joseph Baumann</u>				14. MOTHER'S MAIDEN NAME <u>Justina Dga</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-32-0571</u>			
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis -</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C.V. disease & Cerebral</u> DUE TO <u>Vas. Accident -</u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 1, 1889</u> to <u>MAR 3, 1960</u> , that I last saw the deceased alive on <u>MAR 3, 1960</u> , and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Randallstown Md</u> DATE SIGNED <u>3/5/60</u> ACTUAL SIGNATURE <u>Thomas E. Wheeler</u> M.D. <u> </u> PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 7, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>MAR 8 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Time of death: _____

8. Cause of death: _____

9. Place of death: _____

10. Signature of attending physician: _____

11. Signature of registrar: _____

12. Signature of informant: _____

13. Name of informant: _____

14. Address of informant: _____

15. Date of filing: _____

16. File number: _____

17. Registrar's office: _____

18. County: _____

19. State: _____

20. City: _____

21. Zip: _____

22. Telephone: _____

23. Fax: _____

24. E-mail: _____

25. Website: _____

26. Social Security Number: _____

27. Driver's License Number: _____

28. Vehicle Registration Number: _____

29. Voter Registration Number: _____

30. Other Identification Number: _____

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2920 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02883

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u>		c. LENGTH OF STAY IN lb <u>Baltimore</u> 3001.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethlehem Steel Company Dispensary</u>		d. STREET ADDRESS <u>4612 Kavon Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Stewart F Bean</u>		4. DATE OF DEATH Month Day Year <u>3 2 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 6, 1892</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hot strip mill</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Bean</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No.</u>		16. SOCIAL SECURITY NO. Address <u>Mrs. Eleanora Bean 4612 Kavon Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Jack C Collins</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Jack C Collins</u>		DATE SIGNED <u>3-2-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/5/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Parkville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 4210 Belair Road.</u>		24a. REC'D BY REGISTRAR <u>MAR 3 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles L. Frank</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 2 should be retained for your files. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be retained for your files. Page 2 should be retained for your files. Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2921

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02884

1. PLACE OF DEATH a. COUNTY <u>At Sea Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Minnesota</u> b. COUNTY <u>60X-3</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shoreview Point</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Detroit Lakes</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Aboard S.S. Santore (died at sea)</u>			d. STREET ADDRESS <u>905 Lincoln Avenue</u>		
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Howard</u> Last <u>Belyea</u>			4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1960</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>March 13, 1925</u>		9. AGE (In years last birthday) <u>35</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant Marine</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shipping</u>		11. BIRTHPLACE (State or foreign country) <u>Erskine, Minnesota</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>A. E. Belyea</u>		14. MOTHER'S MAIDEN NAME <u>Elsie Erickson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>1948-1950</u>		17. INFORMANT <u>West Funeral Home, Detroit Lakes, Minnesota</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Sub AR ACHNOID Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive C-V Disease</u> (c) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3/28/60</u>	
EXAMINER'S NAME (Type) <u>M.B. DAVIS M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>3-30-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lemia Lutheran Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Winger, Minnesota</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>			
24a. REC'D BY REGISTRAR <u>APR 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>			

2

FOR STATE
HEALTH DEPT.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of Birth: [illegible]
5. Place of Birth: [illegible]
6. Usual Residence: [illegible]
7. Date of Death: [illegible]
8. Time of Death: [illegible]
9. Place of Death: [illegible]
10. Cause of Death: [illegible]
11. Manner of Death: [illegible]
12. Signature of Medical Examiner: [illegible]
13. Date of Certificate: [illegible]

2922

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02885

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b in transit		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville-8			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Liberty Road				d. STREET ADDRESS Box 283- Route 7		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RICHARD Middle GLEN Last BENNETT				4. DATE OF DEATH Month March Day 18 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 18, 1914		9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe fitter		10b. KIND OF BUSINESS OR INDUSTRY Ship Building		11. BIRTHPLACE (State or foreign country) Keyser, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Bennett				14. MOTHER'S MAIDEN NAME Zula B. Wymer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-12-0132		17. INFORMANT Address Mrs. Helen Ostrow, 5510 Park Hts. Ave., Balto. 15, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Communitied fracture of right knee, Fracture of 812 X DUE TO left femur, Multiple fractures of the pelvis, Conditions, if any, which gave rise to immediate cause (b) Fractured skull (c) _____ DUE TO _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							INTERVAL BETWEEN ONSET AND DEATH 30 min.
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by automobile					
20c. TIME OF INJURY Month, Day, Year Hour 7:30 Mar. 18 1960		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Liberty Rd.		20f. (City or town) (County) (State) Randallstown, Balto., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D. D. CAPLES, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 3-19-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-23-60		22c. NAME OF CEMETERY OR CREMATORY Queens Point Cemetery		22d. LOCATION (City, town, or county) (State) Keyser, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers, 8728 Liberty Rd., Randallstown, Md.				24a. REC'D BY REGISTRAR MAR 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

2802 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]		4. RACE [REDACTED]		5. DATE OF BIRTH [REDACTED]		6. PLACE OF BIRTH [REDACTED]		7. MARITAL STATUS [REDACTED]		8. OCCUPATION [REDACTED]		9. PLACE OF DEATH [REDACTED]		10. DATE OF DEATH [REDACTED]		11. TIME OF DEATH [REDACTED]		12. SIGNATURE OF EXAMINER [REDACTED]		13. OFFICIAL SEAL [REDACTED]	
14. CAUSE OF DEATH [REDACTED]		15. MANNER OF DEATH [REDACTED]		16. MEDICAL HISTORY [REDACTED]		17. PRESENT ILLNESS [REDACTED]		18. POST-MORTEM FINDINGS [REDACTED]		19. TOXICOLOGICAL ANALYSIS [REDACTED]		20. OTHER FINDINGS [REDACTED]		21. SIGNATURE OF ASSISTANT EXAMINER [REDACTED]		22. OFFICIAL SEAL [REDACTED]		23. DATE OF EXAMINATION [REDACTED]		24. TIME OF EXAMINATION [REDACTED]		25. SIGNATURE OF WITNESS [REDACTED]		26. OFFICIAL SEAL [REDACTED]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached and used for the burial-transit permit. Then please remove carbon pages 1 and 2 and fill with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

2923

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02886

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY 1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 14 MONTHS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		3 Vol. 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		d. STREET ADDRESS 4416 OLDFREDERICK RD	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle P. Last BEVANS		4. DATE OF DEATH Month MARCH Day 16 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/30/1871
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S	
13. FATHER'S NAME JAMES L. BEVANS		14. MOTHER'S MAIDEN NAME SARAH F. PEOUZZI	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-12-0317	
17. INFORMANT Frank L. Smith Jr.		Address Cockeysville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Atherosclerotic Carditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-19 19 59 , to 3-16 19 60 , that (I) (we) last saw the deceased alive on 3-16 19 60 , and that death occurred at 7:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees		22b. DATE SIGNED 3/16/60	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 19, 1960	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc.		ADDRESS 1217 St. Paul St.	
25a. REC'D BY REGISTRAR DATE MAR 18 '60		25b. REGISTRAR'S SIGNATURE Orthur S. Kram	

4228

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
STATE OF OHIO

1900

1

CHIEF CLERK



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02887

Reg. Dist. No.

2924

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b 5 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3611 Blackstone Road		d. STREET ADDRESS 3611 Blackstone Road	
3. NAME OF DECEASED (Type or print) First Anna Middle Augusta Last Bishop		4. DATE OF DEATH Month 3 Day 14 Year 19 60	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> *****	8. DATE OF BIRTH Feb. 13, 1872
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME August Snider		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. *****	
17. INFORMANT Mr. Frederick W. Bishop		Address 3611 Blackstone Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident - C 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.V. disease & Renal Failure DUE TO (c) Generalized arteriosclerosis - severe		INTERVAL BETWEEN ONSET AND DEATH 2 days 5 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 15 , 19 59 , to MAR 14 , 19 60 , that I last saw the deceased alive on MAR 14 , 19 60 , and that death occurred at 2 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Thomas E. Wheeler M.D. 3601 Olifmar Road			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Dr. Thomas E. Wheeler	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/17/60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		22d. LOCATION (City, town, or county) (State) Randallstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers		ADDRESS 8728 Liberty Road	
24a. REC'D BY REGISTRAR DATE MAR 23 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Randallstown, Md.

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2925

MD
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02888

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balte</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Balte</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural - Balte</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5506 Willys Ave</u>		1 d. STREET ADDRESS <u>5506 Willys Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGIA</u> <u>CELTUDE</u> <u>BLACK</u>		4. DATE OF DEATH Month Day Year <u>MARCH</u> <u>2</u> <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 Oct 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>unknown Brit</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George A. Bragg</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Grinnan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>374449</u>	
17. INFORMANT <u>Mr. Henry - 5506 Willys</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C-V-Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1 Jan</u> 19 <u>58</u> to <u>22 Mar</u> 19 <u>60</u> ; that (I) (we) last saw the deceased alive on <u>2 Mar</u> 19 <u>60</u> , and that death occurred at <u>2:30 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>William Goodman</u> M.D.		22b. DATE SIGNED <u>2 Mar 60</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM GOODMAN, M.D.</u>		22d. ADDRESS <u>1334 SULPHUR SPRING ROAD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/15/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Elkridge, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>		25a. REC'D BY REGISTRAR <u>MAR 7 '60</u>	
ADDRESS <u>4107 Wilkens Avenue</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

11/2/23

DATE OF DEATH

11/2/23

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "John" and "Mary" are faintly visible.]



2926

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anneslie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armcast Nursing Home 812 Regester Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mrs. Frances Walton Blaney		4. DATE OF DEATH March 10, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3 1875
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Department Store	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Hutchenson		14. MOTHER'S MAIDEN NAME Culbert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 217-03-1836	
17. INFORMANT George D. Blaney, 806 E. Belvedere Ave, Balto. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Decompensation 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Renal Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 1 Month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1948 to March 10, 1960 , that I last saw the deceased alive on March 10, 1960 , and that death occurred at 11:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		ADDRESS (Street, city or town, state) 7501 York Rd. Towson Maryland	
DATE SIGNED 3/10/60			
PHYSICIAN'S NAME (Type) CHARLES F. O'DONNELL		7501 York Rd. Towson Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 14, 1960	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	22d. LOCATION (City, town, or county) (State) Pikesville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Burgess Funeral Home		ADDRESS 3631 Falls Road	
24a. REC'D BY REGISTRAR Mar 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

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211-03-1000 (George D. Hickey, 600 N. 1st Street, St. Paul, Minn.)

MEDICAL CERTIFICATION

VS A1S (4)
15M 10/57

CERTIFICATE OF DEATH

Form No. 10

17

17



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrars should be detached and use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2927 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**
Item 1 Film G259 3-28-60 at
CERTIFICATE OF DEATH

02891

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paradise Nursing Home</u> <u>1199 N. 11th St. Catonsville</u>		d. STREET ADDRESS <u>1 1601 Jackson St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sadie C. Bloom</u> First Middle Last		4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-2-83</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Geo Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Family</u>	
17. INFORMANT <u>Family</u>		Address <u>Some</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-2-</u> <u>1959</u> , to <u>3-19-</u> <u>1960</u> , that I last saw the deceased alive on <u>3-19-</u> <u>1960</u> , and that death occurred at <u>6: A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilmer K. Gallager</u> M.D. <u>6209 Frederick Road</u>		DATE SIGNED <u>3-19-60</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallager</u> <u>Baltimore-282</u> <u>MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-22-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Abingdon, Ind.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McBride Funeral Home 130 E Fort Ave</u>		24a. REC'D BY REGISTRAR <u>MAR 21 '60</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2928

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02892

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 ESSEX	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 706 MACE AVE			1d. STREET ADDRESS 706 MACE AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle BLOSS Last BLOSS			4. DATE OF DEATH Month MAR. Day 20 Year 1960		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE-7-1887 72 yrs.		9. AGE (In years last birthday) 72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTO. MD.	
10c. CITIZEN OF WHAT COUNTRY? U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ALBERT WIETSCHER			14. MOTHER'S MAIDEN NAME ANNA MARIE GEBB		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT CHAS. BLOSS Address SAME AS ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Generalized Arter. Sclerosis Conditions, if any, which gave rise to immediate cause (b) 450.0 DUE TO Generalized Arter. Sclerosis (c) 450.0 DUE TO Generalized Arter. Sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 DUE TO Generalized Arter. Sclerosis					INTERVAL BETWEEN ONSET AND DEATH 15 yrs
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Jack C Collins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3-20-60	
EXAMINER'S NAME (Type) JACK C COLLINS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-23-60		22c. NAME OF CEMETERY OR CREMATORY DAKALAMIN	
22d. LOCATION (City, town, or county) BALTO		22e. (State) MD.			
23. FUNERAL DIRECTOR'S SIGNATURE John S. Connolly		ADDRESS 418 Eastern Blvd. Baltor		24a. RECEIVED BY REGISTRAR MAR 22 1960	
24b. REGISTRAR'S SIGNATURE Arthur S. Knapp					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be returned to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. Pages 1 and 2 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO GENERAL DIRECTOR: A death certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2929

CERTIFICATE OF DEATH

64170
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 4yr26dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forrestville, Maryland	
3. NAME OF DECEASED (Type or print) First Ida Middle R. Last Brady		4. DATE OF DEATH Month March Day 17 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1870
9. AGE (In years last birthday) yrs. 89		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown John DeVaughn		14. MOTHER'S MAIDEN NAME Unknown Sarah Hyde	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, Cardio Vasc. Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis General, severe DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 21, 1956 to March 17, 1960 that I last saw the deceased alive on March 17, 1960 , and that death occurred at 3:35 P.M. from the causes and on the date stated above. DATE SIGNED 3-17-60			
ACTUAL SIGNATURE Stella Wachslar M.D.		DATE APR 18 '60	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/19/60	
22c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		22d. LOCATION (City, town, or county) (State) Forestville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hutchins Bros. Upper Marlboro, Md.		24a. REC'D BY REGISTRAR APR 18 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE C. J. J. J.	

0511

CONTINUATION OF REPORT

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may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, and the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
2930
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
02893

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>				c. LENGTH OF STAY IN 1b <i>52</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>210 Hilton Ave.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Minna H. Brand</i>				4. DATE OF DEATH <i>March 30 1960</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/7/188</i>	9. AGE (In years last birthday) <i>71</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife Domestic</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>George E. Hartung</i>				14. MOTHER'S MAIDEN NAME <i>King</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>J. Harry Brand Jr.</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>						<i>5 min</i>	
420.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) <i>Arteriosclerotic cardiovascular d.</i>	
						(c) <i>with coronary insufficiency</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>8/26</i> 19 <i>59</i> , to <i>3/29</i> 19 <i>60</i> that (I) (we) last saw the deceased alive on <i>3/29</i> 1960, and that death occurred at <i>7:30</i> P.M., from the causes and on the date stated above.							
22a. SIGNATURE <i>James E. Rowe</i>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>James E. Rowe</i>				22d. ADDRESS <i>1011 Frederick Rd. #28, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4/11/60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine</i>		23d. LOCATION (City, town, or county) (State) <i>Balto. Co. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Marshall & Son 28</i>				25a. REC'D BY REGISTRAR DATE <i>APR 4 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Brand</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2931

CERTIFICATE OF DEATH

02894

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>				c. LENGTH OF STAY IN 1b <u>54</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>IVY HALL CONV. HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>C</u> Last <u>BRANGAN</u>				4. DATE OF DEATH Month <u>MAR</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-12-06</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>WILLIAM M GRAIG</u>				14. MOTHER'S MAIDEN NAME <u>EDITH LARKIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>PALMER GRAIG (SAME AS ABOVE)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Oedema</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac Decomensation</u> DUE TO (c) <u>Diabetes Mellitus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 year</u> <u>3 years?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 8, 1955</u> to <u>March 28, 1960</u> , that I last saw the deceased alive on <u>March 28, 1960</u> , and that death occurred at <u>12:15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Morris A. Jacobs</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>1010 North Point Rd Baltimore 24 Md. 3/29/60</u>			
PHYSICIAN'S NAME (Type) <u>MORRIS A. Jacobs M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-31-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MORELANDS</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Connelly 418 Eastern Blvd.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2532
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02895

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Granite</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>JOHN H. BRANTLEY</i>		4. DATE OF DEATH <i>March 6 1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 26, 1876</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stone Cutter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Marble</i>	
11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>James C. Brantley</i>		14. MOTHER'S MAIDEN NAME <i>Martha Jane Kitchen</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>		16. SOCIAL SECURITY NO. <i>213-12-4198</i>	
17. INFORMANT <i>Mrs. Mary Ann Brantley - Wife</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> <i>442X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertension C.V. disease - cerebral</i> DUE TO (c) <i>Failure + Peripheral vascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>10 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>-</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>MARCH 1, 1960</i> to <i>MAR 6, 1960</i> , that (I) (we) last saw the deceased alive on <i>MAR 6, 1960</i> and that death occurred at <i>5 P.</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Thomas E. Wheeler</i>		22b. DATE SIGNED <i>3/7/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>THOMAS E. WHEELER</i>		22d. ADDRESS <i>RANDALLSTOWN - MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3-9-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Granite Presbyterian</i>		23d. LOCATION (City, town, or county) (State) <i>Granite, Baltimore, Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur A. Haight</i>		25a. REC'D BY REGISTRAR <i>MAR 10 1960</i>	
ADDRESS <i>Dyersville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hains</i>	

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Time of death: _____
8. Cause of death: _____
9. Place of death: _____
10. Signature of physician: _____
11. Signature of registrar: _____
12. Date of registration: _____



2933

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ebenezer Rd. Chase, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nellie Middle Brazier Last Brazier		4. DATE OF DEATH Month March Day 16 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-23-1880
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min.	11. IF UNDER 24 HRS. Months 79 Days 79 Hours 79 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Chase, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Milke		14. MOTHER'S MAIDEN NAME Magdalena Doll	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
INFORMANT Mr. Howard E. Brazier		Address Ebenezer Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) ARTERIO-SCLEROTIC HEART DUE TO (c) DISEASE			INTERVAL BETWEEN ONSET AND DEATH INSTANT. 12 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE , 19 48 , to MARCH 16 , 19 60 , that I last saw the deceased alive on MARCH 15 , 19 60 , and that death occurred at 8 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Miceli M.D.		ADDRESS (Street, city or town, state) 108 S. TAYLOR AVE	
PHYSICIAN'S NAME (Type) JOSEPH MICELI		DATE SIGNED 3/18/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-19-60	
22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		22d. LOCATION (City, town, or county) (State) Chase Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Louise Ann Home 7401 Belair Rd.		24a. REC'D BY REGISTRAR MAR 21 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. King			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE

CAUSE

AGE

SEX

112

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

SEX

AGE

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

SEX

AGE

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

SEX

2934

CERTIFICATE OF DEATH

02897

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>3yrlmth18dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Clifton</u> Middle <u>A.</u> Last <u>Breitenbach</u>				4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 17, 1906</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>paper cutter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Unknown Charles Breitenbach</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Oehler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or dates of service) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>212-01-2672</u>			
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated c Cereb. atroph.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb. 26</u> , 19 <u>60</u> , to <u>March 2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>March 2</u> , 19 <u>60</u> , and that death occurred on <u>11:50 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>3-3-60</u>							
ACTUAL SIGNATURE <u>Bruno Radauskas</u>				M.D. <u>SPRING GROVE STATE HOSPITAL</u>			
PHYSICIAN'S NAME (Type) <u>Bruno Radauskas, M. D.</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 7, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. Stevens, Inc.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

FORT AVE.

5

2000



2893

CERTIFICATE OF DEATH

02898

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charles County</u>	
c. LENGTH OF STAY IN 1b <u>14 YRS</u>		d. STREET ADDRESS <u>1 Charles County</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>877 N. Avondale Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOTTIE Jones Briscoe</u>		4. DATE OF DEATH Month Day Year <u>March 2, 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8, 1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min. <u>10 2 - -</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cafe</u>	
11. BIRTHPLACE (State or foreign country) <u>Charles County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alfred Jones</u>		14. MOTHER'S MAIDEN NAME <u>Emma Proctor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-14-7933</u>	
17. INFORMANT Address <u>Mary Walker 877 N. Avondale Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephritis</u> DUE TO (c) <u>ARTERIO-SCLEROSIS (Nonrenal)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 mo 3</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH 2, 1960</u> to <u>MARCH 3, 1960</u> that I last saw the deceased alive on <u>MARCH 2, 1960</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Prado</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>140 Oak Avenue 3-2-60</u>	
PHYSICIAN'S NAME (Type) <u>William C. Wade, M.D.</u>		<u>Dundalk 22, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>3-8-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Smith Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Pesach Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson & Jenkins</u>		ADDRESS <u>4804 McCaw Ave</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached and taken to the burial-transit permit. Then please remove carbon copy of page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2935 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02899

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville - Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore rural</u>	
c. LENGTH OF STAY IN 1b <u>27</u>		d. STREET ADDRESS <u>2800 Linwood</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2800 Linwood Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES Alexander Brooks</u>		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12. 1898</u>
9. AGE (in years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>219 32 6612</u>	
17. INFORMANT <u>Mrs. Eva Brooks, 2800 Linwood Ave.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure - Pulmonary Edema</u> 241X DUE TO (b) <u>Cor Pulmonale</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Chronic Asthma</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John C. Hyle</u>		DATE SIGNED <u>3-25-60</u>	
EXAMINER'S NAME (Type) <u>JOHN C. HYLE</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-28-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Me. Park. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook Blight Inc. 6009 Harford Rd. Balto.</u>		24a. REC'D BY REGISTRAR <u>MAR 28 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO GENERAL DIRECTOR: Pages 1 and 2 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

0220

MASSACHUSETTS DEPARTMENT OF HEALTH - BARNHART 16
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

1. NAME OF DECEASED: JOHN J. BARNHART

2. SEX: MALE

3. AGE: 45

4. DATE OF DEATH: 10/15/1916

5. PLACE OF DEATH: HOME

6. CAUSE OF DEATH: HEART DISEASE

7. MANNER OF DEATH: NATURAL

8. SIGNATURE OF EXAMINER: [Signature]

9. DATE OF EXAMINATION: 10/15/1916

10. PLACE OF EXAMINATION: HOME

11. SIGNATURE OF WITNESS: [Signature]

12. DATE OF WITNESS: 10/15/1916

13. PLACE OF WITNESS: HOME

14. SIGNATURE OF CORONER: [Signature]

15. DATE OF CORONER: 10/15/1916

16. PLACE OF CORONER: HOME

17. SIGNATURE OF JURY: [Signature]

18. DATE OF JURY: 10/15/1916

19. PLACE OF JURY: HOME

20. SIGNATURE OF JUDGE: [Signature]

21. DATE OF JUDGE: 10/15/1916

22. PLACE OF JUDGE: HOME

23. SIGNATURE OF CLERK: [Signature]

24. DATE OF CLERK: 10/15/1916

25. PLACE OF CLERK: HOME

26. SIGNATURE OF SHERIFF: [Signature]

27. DATE OF SHERIFF: 10/15/1916

28. PLACE OF SHERIFF: HOME

29. SIGNATURE OF CONSTABLE: [Signature]

30. DATE OF CONSTABLE: 10/15/1916

31. PLACE OF CONSTABLE: HOME

32. SIGNATURE OF TOWNSHIP CLERK: [Signature]

33. DATE OF TOWNSHIP CLERK: 10/15/1916

34. PLACE OF TOWNSHIP CLERK: HOME

35. SIGNATURE OF COUNTY CLERK: [Signature]

36. DATE OF COUNTY CLERK: 10/15/1916

37. PLACE OF COUNTY CLERK: HOME

38. SIGNATURE OF STATE CLERK: [Signature]

39. DATE OF STATE CLERK: 10/15/1916

40. PLACE OF STATE CLERK: HOME

41. SIGNATURE OF DEPARTMENT CLERK: [Signature]

42. DATE OF DEPARTMENT CLERK: 10/15/1916

43. PLACE OF DEPARTMENT CLERK: HOME

44. SIGNATURE OF HEALTH DEPT. CLERK: [Signature]

45. DATE OF HEALTH DEPT. CLERK: 10/15/1916

46. PLACE OF HEALTH DEPT. CLERK: HOME

47. SIGNATURE OF BARNHART CLERK: [Signature]

48. DATE OF BARNHART CLERK: 10/15/1916

49. PLACE OF BARNHART CLERK: HOME

50. SIGNATURE OF BARNHART DEPT. CLERK: [Signature]

51. DATE OF BARNHART DEPT. CLERK: 10/15/1916

52. PLACE OF BARNHART DEPT. CLERK: HOME

53. SIGNATURE OF BARNHART STATE CLERK: [Signature]

54. DATE OF BARNHART STATE CLERK: 10/15/1916

55. PLACE OF BARNHART STATE CLERK: HOME

56. SIGNATURE OF BARNHART DEPARTMENT CLERK: [Signature]

57. DATE OF BARNHART DEPARTMENT CLERK: 10/15/1916

58. PLACE OF BARNHART DEPARTMENT CLERK: HOME

59. SIGNATURE OF BARNHART HEALTH DEPT. CLERK: [Signature]

60. DATE OF BARNHART HEALTH DEPT. CLERK: 10/15/1916

61. PLACE OF BARNHART HEALTH DEPT. CLERK: HOME

62. SIGNATURE OF BARNHART BARNHART CLERK: [Signature]

63. DATE OF BARNHART BARNHART CLERK: 10/15/1916

64. PLACE OF BARNHART BARNHART CLERK: HOME

65. SIGNATURE OF BARNHART BARNHART DEPT. CLERK: [Signature]

66. DATE OF BARNHART BARNHART DEPT. CLERK: 10/15/1916

67. PLACE OF BARNHART BARNHART DEPT. CLERK: HOME

68. SIGNATURE OF BARNHART BARNHART STATE CLERK: [Signature]

69. DATE OF BARNHART BARNHART STATE CLERK: 10/15/1916

70. PLACE OF BARNHART BARNHART STATE CLERK: HOME

71. SIGNATURE OF BARNHART BARNHART DEPARTMENT CLERK: [Signature]

72. DATE OF BARNHART BARNHART DEPARTMENT CLERK: 10/15/1916

73. PLACE OF BARNHART BARNHART DEPARTMENT CLERK: HOME

74. SIGNATURE OF BARNHART BARNHART HEALTH DEPT. CLERK: [Signature]

75. DATE OF BARNHART BARNHART HEALTH DEPT. CLERK: 10/15/1916

76. PLACE OF BARNHART BARNHART HEALTH DEPT. CLERK: HOME

77. SIGNATURE OF BARNHART BARNHART BARNHART CLERK: [Signature]

78. DATE OF BARNHART BARNHART BARNHART CLERK: 10/15/1916

79. PLACE OF BARNHART BARNHART BARNHART CLERK: HOME

80. SIGNATURE OF BARNHART BARNHART BARNHART DEPT. CLERK: [Signature]

81. DATE OF BARNHART BARNHART BARNHART DEPT. CLERK: 10/15/1916

82. PLACE OF BARNHART BARNHART BARNHART DEPT. CLERK: HOME

83. SIGNATURE OF BARNHART BARNHART BARNHART STATE CLERK: [Signature]

84. DATE OF BARNHART BARNHART BARNHART STATE CLERK: 10/15/1916

85. PLACE OF BARNHART BARNHART BARNHART STATE CLERK: HOME

86. SIGNATURE OF BARNHART BARNHART BARNHART DEPARTMENT CLERK: [Signature]

87. DATE OF BARNHART BARNHART BARNHART DEPARTMENT CLERK: 10/15/1916

88. PLACE OF BARNHART BARNHART BARNHART DEPARTMENT CLERK: HOME

89. SIGNATURE OF BARNHART BARNHART BARNHART HEALTH DEPT. CLERK: [Signature]

90. DATE OF BARNHART BARNHART BARNHART HEALTH DEPT. CLERK: 10/15/1916

91. PLACE OF BARNHART BARNHART BARNHART HEALTH DEPT. CLERK: HOME

92. SIGNATURE OF BARNHART BARNHART BARNHART BARNHART CLERK: [Signature]

93. DATE OF BARNHART BARNHART BARNHART BARNHART CLERK: 10/15/1916

94. PLACE OF BARNHART BARNHART BARNHART BARNHART CLERK: HOME

95. SIGNATURE OF BARNHART BARNHART BARNHART BARNHART DEPT. CLERK: [Signature]

96. DATE OF BARNHART BARNHART BARNHART BARNHART DEPT. CLERK: 10/15/1916

97. PLACE OF BARNHART BARNHART BARNHART BARNHART DEPT. CLERK: HOME

98. SIGNATURE OF BARNHART BARNHART BARNHART BARNHART STATE CLERK: [Signature]

99. DATE OF BARNHART BARNHART BARNHART BARNHART STATE CLERK: 10/15/1916

100. PLACE OF BARNHART BARNHART BARNHART BARNHART STATE CLERK: HOME

MASSACHUSETTS DEPARTMENT OF HEALTH - BARNHART 16
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2936

CERTIFICATE OF DEATH

Reg. Dist. No. 02900

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY —		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 24yrs6mths19dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL			d. STREET ADDRESS 1622 East Chase Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Marie Middle Brown Last Brown			4. DATE OF DEATH Month March Day 15 Year 19 60		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1907		9. AGE (In years lost birthday) 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Amos Shopf			14. MOTHER'S MAIDEN NAME Lena Zimmer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown		INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) — DUE TO (c) —					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 14 , 19 60 , to March 15 , 19 60 that I last saw the deceased alive on March 15 , 19 60 , and that death occurred at 6:40a M., from the causes and on the date stated above.					
ACTUAL SIGNATURE Stella Wachslor		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 3-15-60			
PHYSICIAN'S NAME (Type) Stella Wachslor, M. D.		Catonsville 28, Maryland			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 3-18-60		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.	
				22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John B. Miller, Inc.			ADDRESS -2431 E. Oliver St.		24a. REC'D BY REGISTRAR DATE MAR 21 '60
					24b. REGISTRAR'S SIGNATURE Arthur L. Frank

CERTIFICATE OF DEATH

2028

0530

Blank form with horizontal lines for text entry.



CERTIFICATE OF DEATH

Reg. Dist. No.

02901

2937

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Yeoho Road</i>		d. STREET ADDRESS <i>Yeoho Rd</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Benjamin</i> Middle <i>Bond</i> Last <i>Bruehl</i>		4. DATE OF DEATH Month <i>March</i> Day <i>13</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>25 March 1884</i>
9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired Constr</i>	
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George C Bruehl</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Ryan</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220 038164</i>	
17. INFORMANT <i>Daughter</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive arterio-sclerotic Cardio-vascular disease 12 years</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>August 16</i> , 19 <i>60</i> , to <i>March 10</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>March 10</i> , 19 <i>60</i> , and that death occurred at <i>10 A</i> . M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walter T. Kees</i> M.D.		ADDRESS (Street, city or town, state) <i>Cockeysville Maryland</i>	
DATE SIGNED <i>13 March 1960</i>			
PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-16-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Bosley's Methodist</i>	22d. LOCATION (City, town, or county) (State) <i>Sparks, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Brooks Funeral Service, Towson 4, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 15 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kuntz</i>	

1 *4*
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 2938
 CERTIFICATE OF DEATH

02902

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 82 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWARD Middle E. Last BUSCHMANN		4. DATE OF DEATH Month March Day 29 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 6, 1876
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GUSTAV Gustav Charles Buschmann		14. MOTHER'S MAIDEN NAME Amelia Wusterbarth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) SAW 174-09-6930	
17. INFORMANT Clin. Rec. VAH, Balto. 18, Md., Ft. Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) APIRATION BRONCHOPNEUMONIA 465X DUE TO INFARCT OF LUNG Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH HOURS UNK
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Status post operative prostatectomy for carcinoma prostate-1950			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 7, 1960 to March 29, 1960 , that (I) (we) last saw the deceased alive on March 29, 1960 , and that death occurred at 7:20 PM from the causes and on the date stated above.			
22a. SIGNATURE Caridad E. Gonzalez M.D.		22b. DATE SIGNED 3/30/60	
22c. PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 4/2/60	
23c. NAME OF CEMETERY OR CREMATORY Oak Park Cemetery		23d. LOCATION (City, town, or county) (State) New Castle, Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard Ruck		25a. Rec'd BY REGISTRAR APR 1 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Haines			

105412

CERTIFICATE OF DEATH

2338

DECEASED
NAME
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF REGISTRAR
OFFICE OF VITALS
COUNTY OF
STATE OF

ATTESTATION
I, REGISTRAR, do hereby certify that the foregoing is a true and correct copy of the original record of the death of the above named person, as the same appears in the records of the Office of Vital Statistics, County of _____, State of _____, on the _____ day of _____, 19____.

DECEASED
NAME
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF REGISTRAR
OFFICE OF VITALS
COUNTY OF
STATE OF

2939

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Greenway Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Raymond</i> Middle <i>Richard</i> Last <i>Butler</i>		4. DATE OF DEATH Month <i>March</i> Day <i>9</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>23 July 1898</i>
9. AGE (In years last birthday) <i>60</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steelworker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Nuts & Bolts</i>	
11. BIRTHPLACE (State or foreign country) <i>Springfield Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Richard Butler</i>		14. MOTHER'S MAIDEN NAME <i>Anna Swonger</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give war or dates of service) <i>W.W.T.</i>		16. SOCIAL SECURITY NO. <i>080 05 1402</i>	
17. INFORMANT <i>Wife Viola V. Butler</i> Address <i>Same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decomposition</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Cardiovascular disease</i> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> <i>3 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July</i> , 19 <i>60</i> , to <i>March</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>8 March</i> , 19 <i>60</i> , and that death occurred at <i>5:15 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walter T. Kees</i>		ADDRESS (Street, city or town, state) <i>Cockeysville, Md</i> DATE SIGNED <i>9 March 1960</i>	
PHYSICIAN'S NAME (Type) <i>Walter T. Kees</i>		<i>Cockeysville, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>3-14-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Saters Baptist Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore County</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Cook-Towson, Inc., 1050 York Road, Towson</i> ADDRESS		24a. REC'D BY REGISTRAR <i>MAR 11 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>

CERTIFICATE OF DEATH

1933

<p>NAME OF DECEASED [Faint text, possibly "John Doe"]</p>		<p>AGE [Faint text, possibly "45"]</p>		<p>SEX [Faint text, possibly "Male"]</p>		<p>RACE [Faint text, possibly "White"]</p>	
<p>DATE OF DEATH [Faint text, possibly "Jan 15, 1933"]</p>		<p>TIME OF DEATH [Faint text, possibly "10:00 AM"]</p>		<p>PLACE OF DEATH [Faint text, possibly "Home"]</p>		<p>Cause of Death [Faint text, possibly "Heart Disease"]</p>	
<p>Signature of Physician [Faint signature]</p>		<p>Signature of Registrar [Faint signature]</p>		<p>Signature of Coroner [Faint signature]</p>		<p>Signature of Medical Examiner [Faint signature]</p>	
<p>Signature of Burial Officer [Faint signature]</p>		<p>Signature of Undertaker [Faint signature]</p>		<p>Signature of Funeral Home [Faint signature]</p>		<p>Signature of Cemetery [Faint signature]</p>	
<p>Signature of Health Officer [Faint signature]</p>		<p>Signature of State Registrar [Faint signature]</p>		<p>Signature of State Coroner [Faint signature]</p>		<p>Signature of State Medical Examiner [Faint signature]</p>	

2940

CERTIFICATE OF DEATH

02904

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 7nth35days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle James Last Campbell				4. DATE OF DEATH Month March Day 21 Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 4, 1884	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME William J. Campbell				14. MOTHER'S MAIDEN NAME Mildred Hughes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) unknown			
17. INFORMANT Records; SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Pneumonia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from March 15 , 19 60 , to March 21 , 19 60 , that I last saw the deceased alive on March 21 , 19 60 , and that death occurred at 7:50a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Stella Wachslor M.D. SPRING GROVE STATE HOSPITAL 3-21-60 PHYSICIAN'S NAME (Type) Stella Wachslor, M. D. Catonsville 28, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 3/24/60		22c. NAME OF CEMETERY OR CREMATORY RHOADESVILLE CEM. RHOADESVILLE, VA.	
22d. LOCATION (City, town, or county) _____ (State) _____							
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons, Catonsville, Md.				24a. REC'D BY REGISTRAR MAR 23 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

2040

1

STATE OF NEW YORK

0500

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film G260 4/11/60 1b

CERTIFICATE OF DEATH

Reg. Dist. No.

02905

2941

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 61 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2620 Frederick Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lottie Middle Sarah Last Cavey				4. DATE OF DEATH Month March Day 16, Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1875	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 84 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Cogle				14. MOTHER'S MAIDEN NAME Sarah McBride			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Catonsville - 28, Md. Mrs. Doris Lichliter 2620 Frederick Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 21, 1960 to Mar. 16, 1960 , that I last saw the deceased alive on Mar. 15, 1960 , and that death occurred at 2:00 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas F. Herbert		M.D. 46 Church Rd		ADDRESS (Street, city or town, state) 46 Church Rd		DATE SIGNED 3-17-60	
PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.		City, and State Ellicott City, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/19/1960		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons		ADDRESS Catonsville, Md.		24a. REC'D BY REGISTRAR DATE MAR 23 '60		24b. REGISTRAR'S SIGNATURE Orlwin S. Kneib	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

2841



Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through from the reverse side of the page.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2942
CERTIFICATE OF DEATH

02906

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 40 days		d. STREET ADDRESS 1401 N. Charles Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle W. Last CICHY		4. DATE OF DEATH Month March Day 19 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1912
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Cichy		14. MOTHER'S MAIDEN NAME Antoinette Antoszewski	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-09-4726	
17. INFORMANT Clin. Records VAH, Balto. 18, Md., Ft. Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus, Recent Cerebral Vascular Accident with Rt. Hemiparesis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that at (this hospital) attended the deceased from February 8, 1960 to March 19, 1960 that (X) (we) last saw the deceased alive on March 19, 1960 , and that death occurred 9:00AM , from the causes and on the date stated above.			
22a. SIGNATURE Howard C. Kramer M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Howard C. Kramer M.D.		22d. ADDRESS VAH Balto. 18, Md., Ft. Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/23/1960	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George A. Weber 705 S. Ann St.		25a. REC'D BY REGISTRAR MAR 22 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

GEO. A. WEBER FUNERAL HOME, 705 S. ANN ST., BALTO., MD.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2999

CERTIFICATE OF DEATH

Reg. Dist. No.

02907

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 312 Central Avenue				d. STREET ADDRESS 312 Central Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARY Middle REESE Last COCKEY				4. DATE OF DEATH Month March Day 30 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1883		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 30 Days 160
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Reese Arnold				14. MOTHER'S MAIDEN NAME Clayanna Fisher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT John O. Cockey, Glyndon, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchitis 4520 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) 10 yrs.						INTERVAL BETWEEN ONSET AND DEATH 1 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson Syndrome						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m. none		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 1-22-37 , 19____, to 3-30-60 , 19____, that I last saw the deceased alive on 3-28-60 , 19____, and that death occurred at 7 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 3-31-60							
ACTUAL SIGNATURE D. D. Caples		M.D. Reisterstown, Md.					
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 1, 1960		22c. NAME OF CEMETERY OR CREMATORY All Saints' Cemetery		22d. LOCATION (City, town, or county) (State) Reisterstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Beeryman & Sons				ADDRESS Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE APR 4 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached and used as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>	
<p>4. PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>5. DATE OF BIRTH <i>Jan 1, 1920</i></p>		<p>6. PLACE OF DEATH <i>Baltimore, Md.</i></p>	
<p>7. OCCUPATION <i>Teacher</i></p>		<p>8. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>9. MANNER OF DEATH <i>Natural</i></p>	
<p>10. DATE OF DEATH <i>Dec 15, 1965</i></p>		<p>11. TIME OF DEATH <i>10:30 AM</i></p>		<p>12. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>13. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>15. SIGNATURE OF CORONER <i>John Doe</i></p>	
<p>16. SIGNATURE OF JUDGE <i>John Doe</i></p>		<p>17. SIGNATURE OF CLERK <i>John Doe</i></p>		<p>18. SIGNATURE OF NOTARY <i>John Doe</i></p>	
<p>19. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>20. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>21. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>	
<p>22. SIGNATURE OF CORONER <i>John Doe</i></p>		<p>23. SIGNATURE OF JUDGE <i>John Doe</i></p>		<p>24. SIGNATURE OF CLERK <i>John Doe</i></p>	
<p>25. SIGNATURE OF NOTARY <i>John Doe</i></p>		<p>26. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>27. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>28. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>29. SIGNATURE OF CORONER <i>John Doe</i></p>		<p>30. SIGNATURE OF JUDGE <i>John Doe</i></p>	
<p>31. SIGNATURE OF CLERK <i>John Doe</i></p>		<p>32. SIGNATURE OF NOTARY <i>John Doe</i></p>		<p>33. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>34. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>35. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>36. SIGNATURE OF CORONER <i>John Doe</i></p>	
<p>37. SIGNATURE OF JUDGE <i>John Doe</i></p>		<p>38. SIGNATURE OF CLERK <i>John Doe</i></p>		<p>39. SIGNATURE OF NOTARY <i>John Doe</i></p>	
<p>40. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>41. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>42. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>	
<p>43. SIGNATURE OF CORONER <i>John Doe</i></p>		<p>44. SIGNATURE OF JUDGE <i>John Doe</i></p>		<p>45. SIGNATURE OF CLERK <i>John Doe</i></p>	
<p>46. SIGNATURE OF NOTARY <i>John Doe</i></p>		<p>47. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>48. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>49. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>50. SIGNATURE OF CORONER <i>John Doe</i></p>		<p>51. SIGNATURE OF JUDGE <i>John Doe</i></p>	
<p>52. SIGNATURE OF CLERK <i>John Doe</i></p>		<p>53. SIGNATURE OF NOTARY <i>John Doe</i></p>		<p>54. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>55. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>56. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>57. SIGNATURE OF CORONER <i>John Doe</i></p>	
<p>58. SIGNATURE OF JUDGE <i>John Doe</i></p>		<p>59. SIGNATURE OF CLERK <i>John Doe</i></p>		<p>60. SIGNATURE OF NOTARY <i>John Doe</i></p>	
<p>61. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>62. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>63. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>	
<p>64. SIGNATURE OF CORONER <i>John Doe</i></p>		<p>65. SIGNATURE OF JUDGE <i>John Doe</i></p>		<p>66. SIGNATURE OF CLERK <i>John Doe</i></p>	
<p>67. SIGNATURE OF NOTARY <i>John Doe</i></p>		<p>68. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>69. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>70. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>71. SIGNATURE OF CORONER <i>John Doe</i></p>		<p>72. SIGNATURE OF JUDGE <i>John Doe</i></p>	
<p>73. SIGNATURE OF CLERK <i>John Doe</i></p>		<p>74. SIGNATURE OF NOTARY <i>John Doe</i></p>		<p>75. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>76. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>77. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>78. SIGNATURE OF CORONER <i>John Doe</i></p>	
<p>79. SIGNATURE OF JUDGE <i>John Doe</i></p>		<p>80. SIGNATURE OF CLERK <i>John Doe</i></p>		<p>81. SIGNATURE OF NOTARY <i>John Doe</i></p>	
<p>82. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>83. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>84. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>	
<p>85. SIGNATURE OF CORONER <i>John Doe</i></p>		<p>86. SIGNATURE OF JUDGE <i>John Doe</i></p>		<p>87. SIGNATURE OF CLERK <i>John Doe</i></p>	
<p>88. SIGNATURE OF NOTARY <i>John Doe</i></p>		<p>89. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>90. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>91. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>92. SIGNATURE OF CORONER <i>John Doe</i></p>		<p>93. SIGNATURE OF JUDGE <i>John Doe</i></p>	
<p>94. SIGNATURE OF CLERK <i>John Doe</i></p>		<p>95. SIGNATURE OF NOTARY <i>John Doe</i></p>		<p>96. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>97. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>98. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>99. SIGNATURE OF CORONER <i>John Doe</i></p>	
<p>100. SIGNATURE OF JUDGE <i>John Doe</i></p>		<p>101. SIGNATURE OF CLERK <i>John Doe</i></p>		<p>102. SIGNATURE OF NOTARY <i>John Doe</i></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02908

2943

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton, P.O.				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION York Rd., Hereford				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rebecca Middle Lance Last Cole				4. DATE OF DEATH Month 3 Day 1 Year 1960			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-8-1879	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 80 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard Vance				14. MOTHER'S MAIDEN NAME Ella Royston			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT Address Towson 4, Md. Lawrence V. Cole, 1627 Glen Keith Blvd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic cardio vascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gangerne of right lower extremity DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 50 to Mar. 1 , 19 60 , that I last saw the deceased alive on Feb. 29 , 19 60 , and that death occurred at 5 am , from the causes and on the date stated above.							
ACTUAL SIGNATURE A. M. France M.D.				ADDRESS (Street, city or town, state) Parkton, Md. DATE SIGNED 3/2/60			
PHYSICIAN'S NAME (Type) A. M. France							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-4-60		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Methodist		22d. LOCATION (City, town, or county) (State) Parkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.				24a. REC'D BY REGISTRAR MAR 7 '60 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. France	

Brooks Funeral Service, London, Md.

Burial 3-1-60 - 11 AM. Central Methodist, Parkton, Md.

John D. H. Jones

John D. H. Jones

John D. H. Jones

John D. H. Jones

John D. H. Jones

John D. H. Jones

John D. H. Jones

John D. H. Jones

John D. H. Jones

John D. H. Jones

John D. H. Jones

John D. H. Jones

John D. H. Jones

John D. H. Jones

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02909

2944

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3yr8mth21dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Vivian Last Cooksey		4. DATE OF DEATH Month March Day 29 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1886
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	11. IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Cooksey		14. MOTHER'S MAIDEN NAME Mary Matingly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 23, 1960 to March 29, 1960 , that I last saw the deceased alive on March 29, 1960 , and that death occurred at 11:00a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 3-29-60			
ACTUAL SIGNATURE Stella Wachslar M.D.		PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-1-60	
22c. NAME OF CEMETERY OR CREMATORY St Marys		22d. LOCATION (City, town, or county) (State) Bryantown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Thured Home, Waldorf, Md.		24a. REC'D BY REGISTRAR DATE APR 4 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

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08X-2

CERTIFICATE OF DEATH

3044

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached from page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02910

2945

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Maryland</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>2 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>555 Towson</u> d. STREET ADDRESS <u>1219 Bosley Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Claudia Louise Goling</u> First Middle Last 4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1960</u>				5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>4/30/1875</u> 9. AGE (In years last birthday) <u>84</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> 11. BIRTHPLACE (State or foreign country) <u>New York</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Isaac J. Luthiser</u> 14. MOTHER'S MAIDEN NAME <u>Nathurine Bayard</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>Unknown</u> 17. INFORMANT <u>Kenneth Goling</u> Address <u>412 Lambeth Road Baltimore 28 Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Decompensative Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>60</u> , to <u>March 10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>March 10</u> , 19 <u>60</u> , and that death occurred at <u>9 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Laurence C. Post</u> M.D. <u>6805 York Rd.</u> DATE SIGNED <u>3/12/60</u>				ADDRESS (Street, city or town, state) <u>Baltimore 12 Md</u>			
PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3/14/60</u> 22b. DATE THEREOF <u>Angel Hill</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Harold Lane Md</u> 22d. LOCATION (City, town, or county) _____ (State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Laurence C. Post</u> ADDRESS <u>Laurence C. Post, Md.</u>				24a. REC'D BY REGISTRAR <u>Mar 17 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

• **THE CHAIRS**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2946 CERTIFICATE OF DEATH

02911

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 50 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last PRINCE A COOPER		4. DATE OF DEATH Month Day Year MARCH 13 19 60	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 15, 1890
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER (retired) PUBLIC SCHOOL		10b. KIND OF BUSINESS OR INDUSTRY TRAPPE, MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES COOPER		14. MOTHER'S MAIDEN NAME MARY CAMPER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES WW-1		16. SOCIAL SECURITY NO. 219-01-9104	
17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THE SIGMOID COLON WITH 153.3 XXXX WIDESPREAD METASTASES Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation- Nov. 1959, Removal of the sigmoid colon		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 23, 1960 to March 13, 1960 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 13, 1960 , and that death occurred 8:09pm from the causes and on the date stated above.			
22a. SIGNATURE Caridad E. Gonzalez M.D.		22b. DATE 3/14/60	
22c. PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M.D.		22d. ADDRESS VAH, BALTO. 18 MD. FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/15/60	
23c. NAME OF CEMETERY OR CREMATORY PARADISE CEMETERY		23d. LOCATION (City, town, or county) (State) TRAPPE, TALBOT CO., MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808 N. Monroe St. Balto. Md.		25a. REC'D BY REGISTRAR MAR 22 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Harris		25c. DATE MAR 22 '60	

Picked up by Hearse by James Dashiell, Easton, Md. from Phillips Funeral Home, Balto. Md.

2048 - CERVICAL OF TAIL

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WINDING

TRAFFIC

SO LANE

WIND LANE

ROUTE 22 SW 130

STANDARD ADMINISTRATION HOSPITAL

COTTON

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SENT. 12, 1990

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TRAFFIC, WINDING

TRAFFIC (1-11-90) PUBLIC SCHOOL

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WIND LANE DIVISION

WIND LANE - Nov. 1992. Removal of the wind lane

WIND LANE 12, 1990

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WIND LANE 12, 1990

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2947

CERTIFICATE OF DEATH

Reg. Dist. No.

02912

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>1yr3mth27dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>11505 "eisterstown Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>James</u> Last <u>Cordner</u>				4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>July 17, 1890</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>manager of garage</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Simon Cordner</u>				14. MOTHER'S MAIDEN NAME <u>Annie Gardner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>315-25-1398</u> <u>has a card</u>			
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>				20f. (City or town) (County) (State) <u> </u>			
21. I certify that I attended the deceased from <u>Nov. 1</u> , 19 <u>58</u> , to <u>March 8</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>March 8</u> , 19 <u>60</u> , and that death occurred at <u>1:30pm</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>3-8-60</u>							
ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D. <u> </u>							
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u> <u>Catonsville 28, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3-11-60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>GOVANS PRESBYTERIAN CEMETERY</u>				22d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Howell</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 15 '60</u>			
ADDRESS <u>Pikesville Md</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

1943

10-11-43

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02913

2948 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>9mth13dys</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01.4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>735 Edgewood Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Ellen</u> Last <u>Cordray</u>				4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 15, 1895</u>	
9. AGE (In years lost birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>65</u> Days <u>65</u> Hours <u>65</u> Min.		IF UNDER 24 HRS. Months <u>65</u> Days <u>65</u> Hours <u>65</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerical work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. R. R.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Phelix Cordray</u>				14. MOTHER'S MAIDEN NAME <u>Martha Finch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>491X</u> IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General debility</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 15, 1959</u> to <u>March 28, 1960</u> that I last saw the deceased alive on <u>March 28, 1960</u> and that death occurred at <u>9:00a</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL 3-28-60</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 31, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 4210 Belair Road.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

HEALTH - BUREAU OF HEALTH

1

U.S. DEPARTMENT OF HEALTH - BUREAU OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2949

CERTIFICATE OF DEATH

Reg. Dist. No.

02914

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waters Edge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Waters Edge (Dundalk 22)</u>	
c. LENGTH OF STAY IN 1b <u>8 yrs.</u>		d. STREET ADDRESS <u>8109 Bullneck Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8109 Bullneck Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Edward Cranston</u>		4. DATE OF DEATH <u>March 13-60</u> 19 <u>60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 14-1871</u> 89 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper mills</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Making paper</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>John Cranston</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Stafford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>179-22-2491</u>	
17. INFORMANT <u>Lillie Emma Cranston</u>		Address <u>Cranston</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Virus pneumonia</u> <u>444X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I attended the deceased from <u>Jan 1960</u> , 19 <u>60</u> , to <u>March 13, 1960</u> , that I last saw the deceased alive on <u>March 13, 1960</u> , and that death occurred at <u>9:30 AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1077 Main St Balt 22</u> DATE SIGNED <u>3/13/60</u>			
ACTUAL SIGNATURE <u>J. H. Thomas</u> M.D.		PHYSICIAN'S NAME (Type) <u>J. H. Thomas</u> <u>1077 Main St. Balt 22</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/16/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hephzibah Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hephzibah, Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Brooks Bradley, Jr.</u> ADDRESS <u>Dundalk 22</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 16 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneiss</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2000

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		RACE [Faint text, possibly "White"]	
DATE OF DEATH [Faint text, possibly "10/15/1918"]		PLACE OF DEATH [Faint text, possibly "Home"]	
TIME OF DEATH [Faint text, possibly "10:00 AM"]		CAUSE OF DEATH [Faint text, possibly "Pneumonia"]	
PLACE OF BIRTH [Faint text, possibly "Maryland"]		OCCUPATION [Faint text, possibly "Farmer"]	
MARITAL STATUS [Faint text, possibly "Married"]		EDUCATION [Faint text, possibly "High School"]	
RELIGION [Faint text, possibly "Roman Catholic"]		SERVICE [Faint text, possibly "None"]	
SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]		SIGNATURE OF WITNESS [Faint text, possibly "John Doe"]	
SIGNATURE OF PHYSICIAN [Faint text, possibly "John Doe"]		SIGNATURE OF CLERK [Faint text, possibly "John Doe"]	

I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 15th day of October, 1918.

[Faint text, possibly "John Doe"]

[Faint text, possibly "John Doe"]

[Faint text, possibly "John Doe"]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2950 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02915

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret Creamer		4. DATE OF DEATH March 5 / 60 Day Year 19	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1870
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Ott		14. MOTHER'S MAIDEN NAME Kunigunda ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Marie Engelberth Address Engelberth Ave 21 Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 yrs. 4 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from April 5, 1959 to March 5, 1960 , that (I) last saw the deceased alive on March 2, 1960 , and that death occurred at 3AM , from the causes and on the date stated above.	
22a. SIGNATURE Robert J. Lyden, M.D. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ROBERT J. LYDEN, M.D.		22d. ADDRESS 815 Eastern Ave Belt 21, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/8/60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem		23d. LOCATION (City, town, or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair ADDRESS		25a. REC'D BY REGISTRAR MAR 7 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

05445

05445

CERTIFICATE OF AID

3250

OFFICE OF THE
COMMISSIONER OF
THE LAND OFFICE
WASHINGTON, D. C.

MDENARY STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02016

2951

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>3004 Dubois Ave</u> <u>Parkville Md.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u> <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>3004 Dubois Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Frank</u> <u>P.</u> <u>Cremona</u>		4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10 1885</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>10</u> Days <u>5</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Palermo Italy</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u> ✓	
13. FATHER'S NAME <u>Michele Cremona</u>		14. MOTHER'S MAIDEN NAME <u>Carmela Pernice</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>201-14-2187</u>	
17. INFORMANT <u>Mary G. Cremona</u>		Address <u>3004 Dubois Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of rectum</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>59</u> , to <u>Mar. 15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Mar. 14</u> , 19 <u>60</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. A. Grott</u> M.D. <u>8100 Harford Rd.</u>		DATE SIGNED <u>3/15/60</u>	
PHYSICIAN'S NAME (Type) <u>H. A. GROTTO, M.D. Balto 14, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 19-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Della Noce</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 17 '60</u>	
ADDRESS <u>322 S. High St.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

2952 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville 329 Harlem Lane</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City 3001-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Nursing Home</u>		d. STREET ADDRESS <u>1289 William St</u>	
3. NAME OF DECEASED (Type or print) <u>ADELINE CROSBY</u>		4. DATE OF DEATH <u>Tues. March 1st 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 4, 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St. Anne Millersville County, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>St. Anne Millersville County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES TURNER</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE SARAH BELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Robert T. Crosby (Son) 5570</u>	
17. INFORMANT <u>Robert T. Crosby (Son)</u>		Address <u>Baltimore 61, Cecelia Ave. Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Unknown</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2/23/60</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 1, 1959</u> , to <u>3/1, 1960</u> , that I last saw the deceased alive on <u>2/29, 1960</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Curt Koenig</u> M.D.		ADDRESS (Street, city or town, state) <u>4605 Edmonds Ave</u> DATE SIGNED <u>3/2/60</u>	
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIE</u>		Baltimore 19, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 4, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Golden Memorial Cemetery, Crossroads, Millersville, Md.</u>	22d. LOCATION (City, town, or county) (State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Q. Boardman Jones</u>		ADDRESS <u>4005 Charles St. Baltimore, Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Clinton S. Hume</u>	
DATE <u>MAR 3 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the registrar, the registrar should be detached from the certificate and the original certificate should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is mostly blank with some faint markings.

hours after death. Page 4
led in by the funeral director

SPITAL OR ATTENDING
be retained by the hospi
VERAL DIRECTOR: Afte

PHYSICIAN: The law requires that the death certificate be execut
or attending physician.
certificate has been signed by the attending physician and car

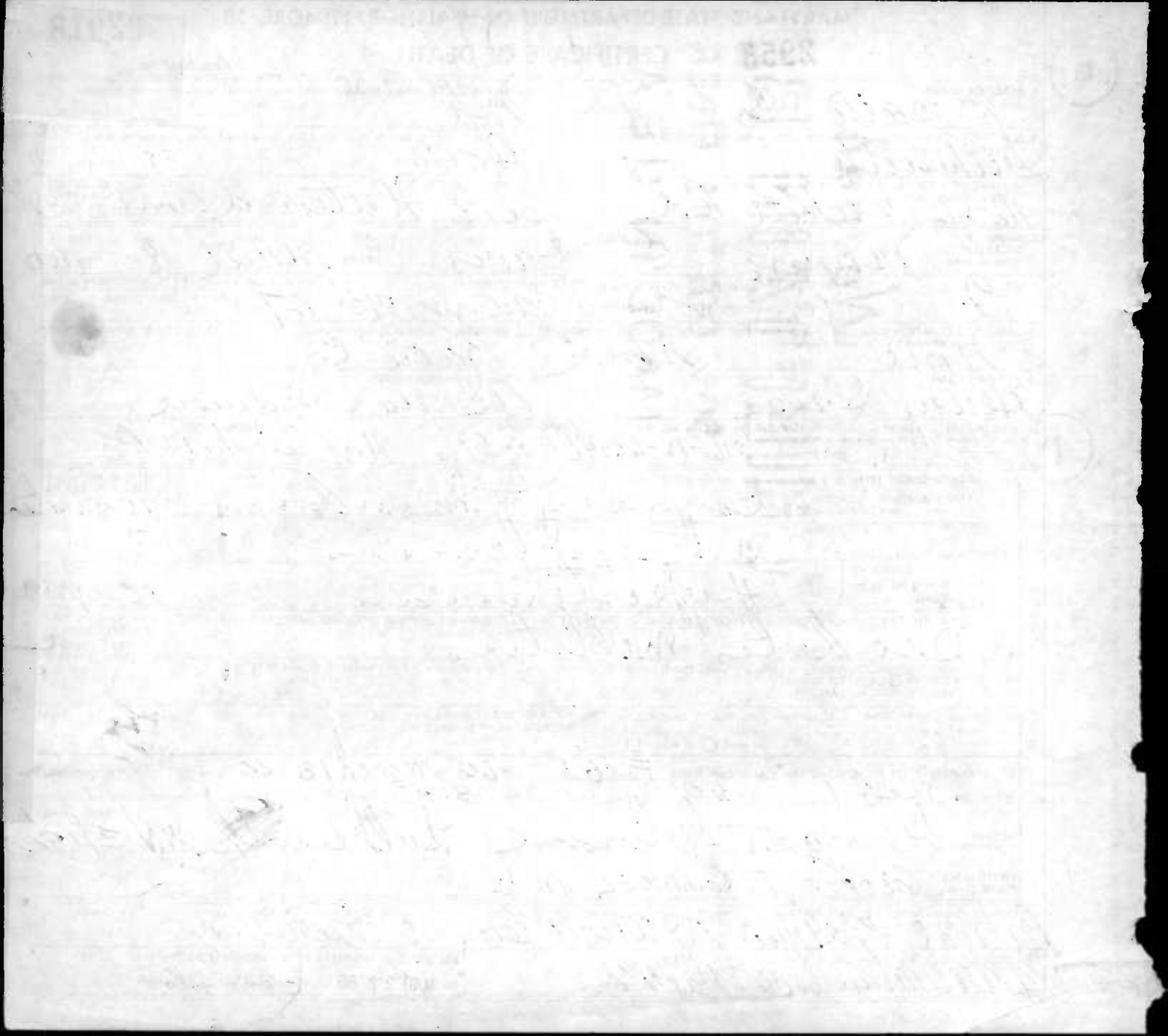
2953

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Bald Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>3V01.4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bald</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <u>1076 Pickett Rd</u>		d. STREET ADDRESS <u>3013 Fleetwood Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>C</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 22 1893</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Bald Co</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Grine</u>		14. MOTHER'S MAIDEN NAME <u>Clorita Bedmore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>216-12-6599</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>?</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 1</u> , 19 <u>60</u> , to <u>March 18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 1</u> , 19 <u>60</u> , and that death occurred at <u>8:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Gilmore</u> M.D.		ADDRESS (Street, city or town, State) <u>Lutherville, MD</u> DATE SIGNED <u>3/19/60</u>	
PHYSICIAN'S NAME (Type) <u>GEORGE T. GILMORE, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3/21/60</u>	<u>McClure Cem</u>	<u>Bald MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William George Hay</u> ADDRESS		24a. REC'D BY REGISTRAR <u>MAR 22 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION



02919

2954

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 12yrlmth24dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore f. STREET ADDRESS 3 N. Potomac Street g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle W. Last DeBald Sr.		4. DATE OF DEATH Month March Day 12 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1897
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic		12. KIND OF BUSINESS OR INDUSTRY mechanic	
13. FATHER'S NAME Andrew Pitt DeBald		14. MOTHER'S MAIDEN NAME Mathilda Teofila ??	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. XXXXXX	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 936.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular disease DUE TO (c) fracture left tibia		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> unknown		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. was found at 11: a. m. on 3-8-60 with a dislocated right femur. Just how this happened is not known.	
21. TIME OF INJURY Hour unknown Month, Day, Year ? 19		22. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> hospital	
23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		24. (City or town) Catonsville 28, Maryland	
25. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		26. DATE SIGNED March 13, 1960	
27. ACTUAL SIGNATURE George M. Kieffer		28. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
29. EXAMINER'S NAME (Type) George M. Kieffer, M. D.		30. DATE MAR 15 '60	
31. BURIAL, CREMATION, REMOVAL (Specify) Burial		32. DATE THEREOF March 16, 1960	
33. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemt.		34. LOCATION (City, town, or county) Baltimore, Maryland	
35. FUNERAL DIRECTOR'S SIGNATURE John A. Moran		36. ADDRESS 3000 E. Baltimore St.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. Pages 1 and 2 should be presented to the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02920

2955 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Summit Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GENES</u> Middle <u>DILLEHUNT</u> Last <u>HUNT</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6 - 1878</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FERDINAND DEBOY</u>		14. MOTHER'S MAIDEN NAME <u>BELZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>100N FERRALL 1206 Elm Ridge</u>	
17. INFORMANT <u>JOHN FERRALL</u> Address <u>1206 Elm Ridge</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u> DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. <u>Atherosclerotic CVD</u> 2. <u>Rheumatoid arthritis, severe</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/18</u> 19 <u>60</u> to <u>3/13</u> 19 <u>60</u> , that I last saw the deceased alive on <u>3/18</u> 19 <u>60</u> , and that death occurred at <u>2:30a</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert J. Levickas</u> M.D.		ADDRESS (Street, city or town, state) <u>5305 East Drive</u> DATE SIGNED <u>3/14/60</u>	
PHYSICIAN'S NAME (Type) <u>Herbert J. Levickas</u>		<u>Baltimore-27, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>March-16-60</u>	<u>New Cathedral Bm</u>	<u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Perry</u> ADDRESS <u>5646 Carroll Ave</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
		DATE <u>MAR 28 60</u>	<u>Arthur S. Howard</u>

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. PLACE OF BIRTH Missouri	
5. DATE OF DEATH April 4, 1968		6. TIME OF DEATH 10:00 AM		7. PLACE OF DEATH Room 306, Airport Hotel, Memphis, Tennessee		8. CAUSE OF DEATH Shot - self	
9. MANNER OF DEATH Suicide		10. DISEASE OR INJURY Suicide		11. OCCASION OF DEATH While on the run from the FBI		12. SIGNATURE OF DECEASED James Earl Ray	
13. SIGNATURE OF NEXT OF KIN None		14. SIGNATURE OF PHYSICIAN Dr. J. H. Hume		15. SIGNATURE OF CORONER Dr. J. H. Hume		16. SIGNATURE OF REGISTRAR Dr. J. H. Hume	
17. SIGNATURE OF WITNESSES None		18. SIGNATURE OF DECEASED James Earl Ray		19. SIGNATURE OF DECEASED James Earl Ray		20. SIGNATURE OF DECEASED James Earl Ray	

2956

Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

2957 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02922

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spam Pt Md</u>	c. LENGTH OF STAY IN 1b <u>—</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u> 3V01.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bilk Club Dispensary</u>		d. STREET ADDRESS <u>2660 Harlem ave</u>	
3. NAME OF DECEASED (Type or print) <u>James S. Dunaway</u> First Middle Last		4. DATE OF DEATH <u>March 5</u> 19 <u>60</u> 19	
5. SEX <u>m</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23 1891</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>	11. BIRTHPLACE (State or foreign country) <u>md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Dunaway</u>	
14. MOTHER'S MAIDEN NAME <u>Ackline Scott</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Clara Dunaway</u> Address <u>2660 Harlem ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> <u>851X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>—</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>—</u>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from beam into river at spot.</u>		
20c. TIME OF INJURY <u>1:30</u> o.m. <u>3-4</u> 19 <u>60</u>	20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hyx Pier - spot</u>	20f. (City or town) <u>Spam Pt - Balto - Md</u> (County) <u>—</u> (State) <u>—</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M B Davis</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. Davis MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-10-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Chapel cem</u>
22d. LOCATION (City, town, or county) <u>Northumberland Co Pa</u>		(State) <u>—</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George B. Nelson</u> ADDRESS <u>1348 N. Calhoun st</u>		24a. REGISTRY REGISTAR DATE <u>MAR 9 '60</u>	24b. REGISTRY REGISTAR'S SIGNATURE <u>Arthur L. Thomas</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 2 should be used as a burial-transit permit. File pages 1 and 2 in the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11-2-53

<p>1. NAME OF DECEASED: _____</p>	
<p>2. SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE</p>	
<p>3. AGE: _____</p>	
<p>4. DATE OF BIRTH: _____</p>	
<p>5. PLACE OF BIRTH: _____</p>	
<p>6. OCCUPATION: _____</p>	
<p>7. CAUSE OF DEATH: _____</p>	
<p>8. MANNER OF DEATH: _____</p>	
<p>9. SIGNATURE OF EXAMINER: _____</p>	
<p>10. DATE OF EXAMINATION: _____</p>	
<p>11. PLACE OF EXAMINATION: _____</p>	
<p>12. SIGNATURE OF WITNESS: _____</p>	
<p>13. DATE OF SIGNATURE: _____</p>	
<p>14. PLACE OF SIGNATURE: _____</p>	
<p>15. SIGNATURE OF SECOND WITNESS: _____</p>	
<p>16. DATE OF SIGNATURE: _____</p>	
<p>17. PLACE OF SIGNATURE: _____</p>	
<p>18. SIGNATURE OF THIRD WITNESS: _____</p>	
<p>19. DATE OF SIGNATURE: _____</p>	
<p>20. PLACE OF SIGNATURE: _____</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2958 CERTIFICATE OF DEATH

Reg. Dist. No.

02923

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore -18		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 500 Hatherleigh Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Myrtle Middle Roberts Last Duncan		4. DATE OF DEATH Month March Day 29 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1886
9. AGE (In years last birthday) 73		10. IF UNDER 1 YEAR Months 7 Days 29 Hours 19 Min. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Baltimore	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph R. Roberts		14. MOTHER'S MAIDEN NAME Margaret A. Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) I		16. SOCIAL SECURITY NO. Informant Address Roy Singleton Duncan, 500 Hatherleigh Road	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 353.1 epilepsy, grand mal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1st ant. arterio sclerosis 1st hyper tension (b) 1st ant. arterio sclerosis (c) 1st hyper tension		INTERVAL BETWEEN ONSET AND DEATH 12 hrs 4 yrs 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/27 , 19 60 to 3/29 , 19 60 that I last saw the deceased alive on 3/27 , 19 60 , and that death occurred at 4 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Geo. W. DeLoof		ADDRESS (Street, city or town, state) 2000 N. Charles DATE SIGNED 3/29/60	
PHYSICIAN'S NAME (Type) Geo. W. DeLoof			
22a. BURIAL, CREMATION, REB. (Specify) Burial		22b. DATE THEREOF 4/2/60	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Road, Towson 4		24a. REC'D BY REGISTRAR APR 1 '60 24b. REGISTRAR'S SIGNATURE Arthur L. Haines	

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1. *Journal of the American Medical Association*, 1997; 277: 1039-1043.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2959 CERTIFICATE OF DEATH

02924

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 10 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Charles College		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rev. William F. Dwyer S.S.		4. DATE OF DEATH Month March Day 10 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1895
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roman Catholic Priest		10b. KIND OF BUSINESS OR INDUSTRY Religious	
11. BIRTHPLACE (State or foreign country) Hartford, Conn.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Dwyer		14. MOTHER'S MAIDEN NAME Elizabeth Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT St. Charles College		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis with hypertension (c) 14 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 3/10 , 19 45 , to 3/10 , 19 60 , that I last saw the deceased alive on 3/10 , 19 60 , and that death occurred at 1 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dominic Palagis M.D.		ADDRESS (Street, City or town, state) 3376 Frederick Ave DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/14/60	22c. NAME OF CEMETERY OR CREMATORY St. Charles College	22d. LOCATION (City, town, or county) (State) Catonsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. W. Meaw & Son 805-11 Calvert St.		24a. REC'D BY REGISTRAR MAR 14 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hearn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the funeral director should be detached from the certificate as the burial-transit permit. Then please remove carbon paper and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH-DEATH REGISTRY
CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		DATE OF DEATH MAY 14 1968	
AGE 35		SEX MALE	
RACE WHITE		EDUCATION HIGH SCHOOL	
OCCUPATION CONTRACTOR		MARRIAGE MAY 1967	
PLACE OF BIRTH MEMPHIS, TENN.		PLACE OF DEATH MEMPHIS, TENN.	
CITY MEMPHIS		COUNTY SHELBY	
STATE TENNESSEE		ZIP CODE 38103	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
IMMEDIATE CAUSE CORONARY THROMBOSIS		UNDERLYING CAUSE CORONARY ARTERY DISEASE	
MORBIDITY NO		MORTALITY YES	
CERTIFICATE NO. 12345		REGISTRY NO. 67890	
DATE OF CERTIFICATE MAY 15 1968		SIGNATURE J. E. RAY	
PRINTED NAME JAMES EARL RAY		PRINTED NAME J. E. RAY	
ADDRESS 1234 MAIN ST. MEMPHIS, TENN. 38103		ADDRESS 1234 MAIN ST. MEMPHIS, TENN. 38103	
CITY MEMPHIS		CITY MEMPHIS	
STATE TENNESSEE		STATE TENNESSEE	
ZIP CODE 38103		ZIP CODE 38103	
COUNTRY UNITED STATES OF AMERICA		COUNTRY UNITED STATES OF AMERICA	
DATE OF BIRTH MAY 14 1933		DATE OF DEATH MAY 14 1968	
PLACE OF BIRTH MEMPHIS, TENN.		PLACE OF DEATH MEMPHIS, TENN.	
CITY MEMPHIS		CITY MEMPHIS	
COUNTY SHELBY		COUNTY SHELBY	
STATE TENNESSEE		STATE TENNESSEE	
ZIP CODE 38103		ZIP CODE 38103	
COUNTRY UNITED STATES OF AMERICA		COUNTRY UNITED STATES OF AMERICA	
DATE OF CERTIFICATE MAY 15 1968		DATE OF DEATH MAY 14 1968	
SIGNATURE J. E. RAY		SIGNATURE J. E. RAY	
PRINTED NAME JAMES EARL RAY		PRINTED NAME J. E. RAY	
ADDRESS 1234 MAIN ST. MEMPHIS, TENN. 38103		ADDRESS 1234 MAIN ST. MEMPHIS, TENN. 38103	
CITY MEMPHIS		CITY MEMPHIS	
STATE TENNESSEE		STATE TENNESSEE	
ZIP CODE 38103		ZIP CODE 38103	
COUNTRY UNITED STATES OF AMERICA		COUNTRY UNITED STATES OF AMERICA	

TO GENERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached from the certificate as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2906

2906

CERTIFICATE OF DEATH

02925

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus				c. LENGTH OF STAY IN 1b 3 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5536 Ashbourne Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Jerome M. Eckhardt, Jr.				4. DATE OF DEATH Month Day Year March 20, 1960 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 31, 1926	9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Pemco Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jerome M. Eckhardt, Sr.				14. MOTHER'S MAIDEN NAME Alice G. Lawless			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.11		17. INFORMANT Address Florence E. Eckhardt 5609 Oregon Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA AND PNEUMONITIS 153.3 DUE TO CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO (b) GENERAL CARCINOMATOSIS DUE TO (c) ADENO-CARCINOMA OF THE SIGMOID						INTERVAL BETWEEN ONSET AND DEATH 6 HRS 4 Mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Nov. 2 19 59 to MAR 20 19 60 , that (I) (we) last saw the deceased alive on MAR 20 19 60 , and that death occurred at 9 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Albert R. Wilkerson				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/21/60	
22c. PHYSICIAN'S NAME (Type) Albert R. Wilkerson M.D.				22d. ADDRESS 1200 St. Paul St.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/24/60		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ambrase Inc. 1328 Sulphur Spring Rd.				25a. REC'D BY REGISTRAR DATE MAR 22 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

68032

UNITED STATES DEPARTMENT OF HEALTH

OFFICE OF THE ATTORNEY GENERAL

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2960 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02926

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MD b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 152 KINGSTON PARK RD				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 MIDDLE RIVER		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IRA M. EFFORD JR.				4. DATE OF DEATH MAR. 19 - 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 21-1910	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY H.P. FOLEY CO.		11. BIRTHPLACE (State or foreign country) BALTO. MD		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME IRA M. EFFORD				14. MOTHER'S MAIDEN NAME FISHER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 705-09-8125		17. INFORMANT IRA M. EFFORD 3RD-Box 105 KEITHLEY RD. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 DUE TO Cornary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 17 days
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE JACK C COLLINS				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3-19-60	
EXAMINER'S NAME (Type) JACK C COLLINS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-21-60		22c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John S. Connolly				ADDRESS 418 Eastern Blvd. Balto. 21		24a. REC'D BY REGISTRAR MAR 22 '60	
				24b. REGISTRAR'S SIGNATURE John S. Connolly			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 6 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

2961 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 6yrlmthl2dys		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL			d. STREET ADDRESS 25 Parkway Drive		
3. NAME OF DECEASED (Type or print) First Emmet Middle Arthur Last Elmore			4. DATE OF DEATH Month March Day 1 Year 1960		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 31, 1878		9. AGE (In years lost birthday) yrs. 81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cabinet maker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Arther Elmore			14. MOTHER'S MAIDEN NAME Jenny		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unknown		INFORMANT Address Records; SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from Feb. 12, 1960 , to March 1, 1960 , that I last saw the deceased alive on March 1, 1960 , and that death occurred at 2:20 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 3-1-60			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-4-60	22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	22d. LOCATION (City, town, or county) (State) Wash. D.C.		
23. FUNERAL DIRECTOR'S SIGNATURE SIMMONS BROS		ADDRESS WASH. D. C. 1661 GOOD HOPE RD	24a. REC'D BY REGISTRAR MAR 4 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1921

MADE IN NEW YORK

NOTED

1921

1921

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2962 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02928

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 2yr3mth3dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Lansdowne		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 9 Clyde Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle J. Last Flack				4. DATE OF DEATH Month March Day 21 Year 19 60			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 21, 1878		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME XXXXXX Charles Flack				14. MOTHER'S MAIDEN NAME XXXXXX Dorthea (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 220-07-3850		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 903.7 DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. border vascular disease DUE TO fracture left femur (c) </p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Kniebeker nail was inserted 2-2-66</p> </div> <div style="width: 45%;"> <p>INTERVAL BETWEEN ONSET AND DEATH </p> </div> </div>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ered and fell while walking on porch, sustaining transverse frag. of mid-shaft of left femur.					
20c. TIME OF INJURY Month, Day, Year Hour 1:30 p. m. 1-30 1960		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Catonsville 28, Maryland	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Geo M Kieffer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) George M. Kieffer, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-25-60		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR MAR 24 '60		24b. REGISTRAR'S SIGNATURE William S. House	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____	
PLACE OF BIRTH _____		DATE OF BIRTH _____		TIME OF BIRTH _____	
OCCUPATION _____		CAUSE OF DEATH _____		MANNER OF DEATH _____	
PLACE OF DEATH _____		DATE OF DEATH _____		TIME OF DEATH _____	
SIGNATURE OF MEDICAL EXAMINER _____		SIGNATURE OF WITNESS _____		SIGNATURE OF DECEASED _____	
ADDRESS OF MEDICAL EXAMINER _____		ADDRESS OF WITNESS _____		ADDRESS OF DECEASED _____	
CITY _____		COUNTY _____		STATE _____	
ZIP CODE _____		TELEPHONE _____		FAX _____	
SIGNATURE OF DECEASED _____		SIGNATURE OF WITNESS _____		SIGNATURE OF MEDICAL EXAMINER _____	
ADDRESS OF DECEASED _____		ADDRESS OF WITNESS _____		ADDRESS OF MEDICAL EXAMINER _____	
CITY _____		COUNTY _____		STATE _____	
ZIP CODE _____		TELEPHONE _____		FAX _____	

CERTIFICATE OF DEATH

02929

Reg. Dist. No.

2963

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Josephs Nursing H.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		f. STREET ADDRESS Recedo Knoll-Maiden Choice	
3. NAME OF DECEASED (Type or print) First Middle Last Sister Dora Flottesmesch				4. DATE OF DEATH Month Day Year March 18 1960			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1882		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sister		10b. KIND OF BUSINESS OR INDUSTRY Religious		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry Flottesmesch				14. MOTHER'S MAIDEN NAME -----			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT Address Sister Clara - Recedo Knoll			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 wks 5+ yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 3, 1960 , to March 19, 1960 , that I last saw the deceased alive on 3/19 , 19 60 , and that death occurred at 4:35 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Victor F. Zing				ADDRESS (Street, city or town, state) 1102 E. Joppy Rd		DATE SIGNED 3/19/60	
PHYSICIAN'S NAME (Type) Farley Funeral Home							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-21-60		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home				24a. REC'D BY REGISTRAR DATE MAR 23 '60		24b. REGISTRAR'S SIGNATURE William S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ARMY AND STATE DEPARTMENT OF HEALTH-SALTMORE, IS

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the attending physician. After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the funeral director. After the certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
Item 8, **CERTIFICATE OF DEATH** Film G259,3/24/601b

02930

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 55	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 523 Park Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle ESTELLA Last FOARD		4. DATE OF DEATH Month March Day 16 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1868 February 16, 1858
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Glenn McComas		14. MOTHER'S MAIDEN NAME Catherine Pennington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIO - PNEUMONIA 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from JUL 11 1955 to MAR 16 1960 , that (I) (we) last saw the deceased alive on MAR 16 1960 , and that death occurred at 8 P.M. from the causes and on the date stated above.			
22a. SIGNATURE T. C. Siwinski		22b. DATE SIGNED 3/18/60	
22c. PHYSICIAN'S NAME (Type) T. C. Siwinski		22d. ADDRESS 206 W. Pennsylvania Avenue, Towson 4, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 19, 1960	
23c. NAME OF CEMETERY OR CREMATORY Fork Methodist Cemetery		23d. LOCATION (City, town, or county) (State) Fork, Baltimore Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson 4, Maryland		25a. REC'D BY REGISTRAR DATE MAR 21 '60	
25b. REGISTRAR'S SIGNATURE William S. Frank			

117-1011

LABORATORY REPORT OF DEATH
CERTIFICATE OF DEATH

3884

Baltimore

Maryland

Baltimore

Town

Town

323 Park Avenue

323 Park Avenue

March 16, 1900

ESTABLISHED

February 16, 1898

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White

Female

W

Maryland

in Home

Home

Catharine Lammington

Glenn K. Brown

Family Records

Home

Home

Home

323 Park Avenue, Baltimore, Md.

March 16, 1900

Printed by the Baltimore City Health Department, Baltimore, Md.

John J. Brown, Town & Maryland

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO GENERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 Film 261 4-22-60 et
2965
CERTIFICATE OF DEATH

64200

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 5yr9mth11dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucy Middle Foland Last Foland		4. DATE OF DEATH Month March Day 25 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1873 (?)
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min.	11. IF UNDER 24 HRS. Months 86 Days 86 Hours 86 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 23 , 19 58 , to March 25 , 19 60 , that I lost the deceased alive on March 25 , 19 60 , and that death occurred at 12:15a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 3-25-60 ACTUAL SIGNATURE Stella Wachslar M.D. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11/12/60	
22c. NAME OF CEMETERY OR CREMATORY Univ. of Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Anatomy Board 291 E. Enoch St.		24a. REC'D BY REGISTRAR DATE APR 18 '60	
24b. REGISTRAR'S SIGNATURE C. R. S. Hume			

420.0

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2966

02931

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 9 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle H Last FOOTE				4. DATE OF DEATH Month MARCH Day 5 Year 19 60			
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 9, 1931	
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY AMUSEMENT COMPANY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ARTHUR G FOOTE				14. MOTHER'S MAIDEN NAME MARGARET TALBERT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. PL-28 212-28-1518		17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC PYELONEPHRITIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) STOMATITIS DUE TO PROTEUS VULGARIS							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Feb. 25, 1960 to March 5, 1960 , that (2) (we) last saw the deceased alive on March 5, 1960 , and that death occurred at 10:55am from the causes and on the date stated above.							
22a. SIGNATURE John D. Talbert, M.D.				22b. DATE SIGNED 3/6/60		22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.	
22d. ADDRESS VAH, BALTO., MD. FORT HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-8-60		23c. NAME OF CEMETERY OR CREMATORY CHEW'S MEMORIAL		23d. LOCATION (City, town, or county) (State) WEST RIVER MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese				25a. REC'D BY REGISTRAR DATE MAR 8 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Knaus	
ADDRESS 110 Washington St Annapolis Maryland							

CENTRAL CASE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02933

2967

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 6</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 6</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4920 Hazelwood Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Arthur C.</u> Middle <u>Jorlifer</u> Last <u></u>				4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-7-1905</u>	9. AGE (In years last birthday) yrs. <u>54</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Emp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waste Oil</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William C. Jorlifer</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Eckert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u>217 05 4618</u>		INFORMANT <u>Lillian Jorlifer</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>180X Hypernephroma</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (c) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 1958, to <u>March 27</u> , 1960, that I last saw the deceased alive on <u>March 26</u> , 1960, and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold A. Grott</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>8100 Harford Rd. 3/25/60</u>					
PHYSICIAN'S NAME (Type) <u>HAROLD A. GOTT, MD.</u>		<u>Baltimore - 14, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3-30-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Rd</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>			

CERTIFICATE OF DEATH

1967

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2894 CERTIFICATE OF DEATH

02932

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)				c. LENGTH OF STAY IN 1b 19 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) 1914 Tyler Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES NORMAN FORSYTHE				4. DATE OF DEATH Month March Day 4th Year 19 60			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1894	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Boat Building		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John A. Forsythe				14. MOTHER'S MAIDEN NAME Mary Ann Warfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-10-2839		17. INFORMANT Amelia S. Forsythe		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 1956 to 3-4 , 19 60 , that I last saw the deceased alive on 3-4 , 19 60 , and that death occurred at 2:30 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Jack C. Collins			M.D. 2 Kinship Road		DATE SIGNED 3/5/60		
PHYSICIAN'S NAME (Type) Jack C. Collins, M.D.			Baltimore 22, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/7/60	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc.			ADDRESS Dundalk 22		24a. REC'D BY REGISTRAR DATE MAR 7 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and filed as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

UNITED STATES DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 2, Film G256
Item 3

CERTIFICATE OF DEATH

3/24/60 1b

02934

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3700 Leo St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Francis & Taylor</u>		d. STREET ADDRESS <u>Baltimore 26, Md.</u> <u>3701 Francis St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>G.</u> Last <u>Francis</u>		4. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-15-63</u>
9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Osceola Montgomery</u>		14. MOTHER'S M maiden name <u>Elizabeth Hall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Family - Four</u>	
17. INFORMANT <u>Family - Four</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO <u>Cardio-Vascular disease Senile</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractures of Pelvis</u> <u>2/20/60</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/23</u> 19 <u>60</u> , to <u>3/14</u> 19 <u>60</u> , that I last saw the deceased alive on <u>3/14</u> 19 <u>60</u> , and that death occurred at <u>3432</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eliot W. Johnson</u>		DATE SIGNED <u>3/15/60</u>	
PHYSICIAN'S NAME (Type) <u>Baltimore 29 Md</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/17/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West View</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore 29 Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. G. Foster</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 18 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2969

CERTIFICATE OF DEATH

Reg. Dist. No.

02935

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville - 38</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1408 Edmondson Ave</u>				d. STREET ADDRESS <u>1408 Edmondson Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARIE</u> First Middle Last				4. DATE OF DEATH <u>Mar.</u> Month Day Year <u>30</u> <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 27, 1894</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Kaufmann</u>				14. MOTHER'S MAIDEN NAME <u>Mary Mueller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-07-4604B</u>		17. INFORMANT <u>John Frank</u> Address <u>1408 Edmondson Ave 28</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED CARCINOMATOSIS</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA - L. BREAST.</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 MO</u> <u>3 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 27</u> 19 <u>59</u> , to <u>3/30/60</u> 19 <u>60</u> , that I last saw the deceased alive on <u>3/29/60</u> 19 <u>60</u> , and that death occurred at <u>1 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Herbert W. Lapp</u> M.D.				DATE SIGNED <u>HERBERT W. LAPP, M.D.</u> <u>4804 FREDERICK AVE.</u> <u>BALTIMORE 29, MD. - MI 4-3655</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr 3, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gruid Lodge</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville</u> <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Keifel</u> ADDRESS <u>5311 Edmondson Ave</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After certificate has been signed by the attending physician and completed, page 3 should be detached from the certificate as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2970

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Md. c. LENGTH OF STAY IN 1b 3 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 5, Maryland d. STREET ADDRESS 2022 McElderry Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Fritsch Last Fritsch		4. DATE OF DEATH Month 3 Day 23 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/11/1891
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min.	11. IF UNDER 24 HRS. Months 68 Days 68 Hours 68 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland, Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John George Fritsch - deceased	
14. MOTHER'S MAIDEN NAME Matilda Clopein		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. no		17. INFORMANT Rosewood Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia, right 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Pyelo-nephritis, obstructive DUE TO (c) Ovarian tumor, right - size of football. - 5 years.			INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ovarian tumor, right - size of football. - 5 years.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/1/56 , 19____, to 3/23/60 , 19____, that I last saw the deceased alive on 3/23/60 , 19____, and that death occurred at 3:10a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry G. Butler M.D.		ADDRESS (Street, city or town, state) Owings Mills, Md. DATE SIGNED 3/23/60	
PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.		LOCATION (City, town, or county) (State) Rosewood State Training School	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/26/60	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek ADDRESS 3331 Brehms Lane		24a. REC'D BY REGISTRAR MAR 28 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

2070

Decorded in the City of New York

Decorded in the City of New York

CERTIFICATE OF DEATH

2971

Baltimore

Md.

Baltimore

University

Chesapeake

1030 Colwood Road

1030 Colwood Road

March 27/80

Large

Sept. 11, 1877

Male

USA

Baltimore, Md.

John Brown

7.2.

Catharine

Frederick Rolfe

Wm. L. Rolfe, 1030 Colwood Rd. Sec. 23

Baltimore, Md.

John Brown

John Brown
1030 Colwood Road

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO GENERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2972

CERTIFICATE OF DEATH

Reg. Dist. No.

02938

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. LENGTH OF STAY IN 1b 54	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 338 UPPERLANDING RD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HARDY DOUGLAS GARLAND		4. DATE OF DEATH Month Day Year MAR. 24 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 25-1899
9. AGE (In years last birthday) yrs. 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIVIL ENG.	11. BIRTHPLACE (State or foreign country) ROBINSVILLE N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WM G. GARLAND	
14. MOTHER'S MAIDEN NAME ROSETTA SAWYER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		INFORMANT Address MARY LOUISE (WIFE) SAME AS ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONITIS 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) LUNG ABSCESS (c) BRONCHOGENIC CARCINOMA			INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCTOBER, 1959 , to 3-24 , 19 60 that I last saw the deceased alive on 3-23 , 19 60 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John B. Little		ADDRESS (Street, city or town, state) DATE SIGNED 1515 Martin Blvd, Baltimore, MD	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-26-60	
22c. NAME OF CEMETERY OR CREMATORY SACRED HEART		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Lonnely		24a. REC'D BY REGISTRAR MAR 28 60	
ADDRESS 418 Eastern Blvd Balto. 71,		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

ST. SKOWHEGAN, 49110, 24 DEPT. OF NAT. RES. CHATHAM, N.H.

2907 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Arbutus)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5/ Baltimore (Arbutus)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4821 Fernley Square		d. STREET ADDRESS 4821 Fernley Square	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lionel Middle J. Last Gillis		4. DATE OF DEATH Month March Day 30 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1893
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min.	11. IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY B & O R.R.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Gilbert Gillis		14. MOTHER'S MAIDEN NAME Jane Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 705 03 5078	
17. INFORMANT Christina Gillis		Address 4821 Fernley Sq. #27	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronaries thrombosis 420.1 DUE TO Heart block. Anteriod. C. V. disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) 420.1 DUE TO Heart block. Anteriod. C. V. disease (c) Heart block. Anteriod. C. V. disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 3, 1959 to 3-29, 1960 , that I last saw the deceased alive on 3-29, 1960 , and that death occurred at 8:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Albinas Klimas		DATE SIGNED March 23 1960	
PHYSICIAN'S NAME (Type) Albinas Klimas, M. D.		2030 Wilkens Avenue Balto, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/1/60	22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery Elkridge, Maryland	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	24a. REC'D BY REGISTRAR APR 4 '60
		24b. REGISTRAR'S SIGNATURE Arthur L. Klaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
CERTIFICATE OF DEATH

1. Name of Deceased: [Illegible]
2. Sex: [Illegible]
3. Age: [Illegible]
4. Date of Birth: [Illegible]
5. Date of Death: [Illegible]
6. Place of Death: [Illegible]
7. Cause of Death: [Illegible]
8. Signature of Physician: [Illegible]
9. Signature of Registrar: [Illegible]
10. Date of Registration: [Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2973

CERTIFICATE OF DEATH

Reg. Dist. No.

02940

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 25yr6mth10dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle Goodgal Last —		4. DATE OF DEATH Month March Day 17 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 9, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Russia
13. FATHER'S NAME Solomon Wilkins		14. MOTHER'S MAIDEN NAME Mary Knauer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Basal cell carcinoma of forehead with probable metastases		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1954 to March 17, 1960 , that I last saw the deceased alive on March 17, 1960 , and that death occurred at 3:35 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		DATE SIGNED SPRING GROVE STATE HOSPITAL 3-17-60	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Address Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-20-1960	22c. NAME OF CEMETERY OR CREMATORY Windsor Hill Road	22d. LOCATION (City, town, or county) (State) Bell Me.
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis		24a. REG'D BY REGISTRAR MAR 22 60	
ADDRESS 2100 E. 12th St		24b. REGISTRAR'S SIGNATURE Arthur E. Knaul	

10000

DEPARTMENT OF DEATH

10000



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02941

2974

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3y01.4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Ho. 1002 N. Rolling Rd.				d. STREET ADDRESS 2810 Reisterstown Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LULA Middle E. Last GORDON				4. DATE OF DEATH Month Mar. Day 21 Year 19 60			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 20, 1880	
9. AGE (In years last birthday) 79 yrs.		10. AGE (In years last birthday) 79 yrs.		11. AGE (In years last birthday) 79 yrs.		12. AGE (In years last birthday) 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker (rtd)				10b. KIND OF BUSINESS OR INDUSTRY --			
11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? --			
13. FATHER'S NAME Coleman Van Horn				14. MOTHER'S MAIDEN NAME Louisa --			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. --			
17. INFORMANT Mrs. W. H. Peppler, Jr. - 5512 Wesley Ave.				Address --			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Hypertensive arteriosclerotic cardio vascular disease DUE TO (c) disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Oct. 14, 1946 to March 21, 1960 that (I) (we) last saw the deceased alive on Mar. 20, 1960 , and that death occurred at 2:15 A.M. from the causes and on the date stated above.							
22a. SIGNATURE George A. Knipp				22b. DATE Mar. 21, 1960			
22c. PHYSICIAN'S NAME (Type) George A. Knipp, M. D.				22d. ADDRESS 4116 Edmondson Avenue			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3/23/60			
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.				23d. LOCATION (City, town, or county) (State) Woodlawn, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner & Sons - Balto				25a. REC'D BY REGISTRAR DATE MAR 23 '60			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				17 <i>md</i>			

CERTIFICATE OF DEATH

2974



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02942

2975

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8218 Harris Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Albertina E. Gosnell				4. DATE OF DEATH March 22, 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 26, 1880	
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-Retired				10b. KIND OF BUSINESS OR INDUSTRY Bakery		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Albert Loeffler				14. MOTHER'S MAIDEN NAME Carolina Hess			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-34-1399			
17. INFORMANT Mrs. Margaret Schuler				Address 8218 Harris Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) 3 hours (c) 3 years						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic pyelonephritis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9-8 , 19 59 , to 3-15 , 19 60 , that I lost s/he the deceased alive on 3-15 , 19 60 , and that death occurred at 6:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Santi Amoroso M.D.				ADDRESS (Street, city or town, state) 6801 Belair Road DATE SIGNED			
PHYSICIAN'S NAME (Type) Santi Amoroso							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-25-1960		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 23 '60	
						24b. REGISTRAR'S SIGNATURE Carling S. Krawiec	

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1932

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Place of death: _____
8. Cause of death: _____
9. Signature of physician: _____
10. Signature of registrar: _____
11. Date of registration: _____
12. Place of registration: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2977

CERTIFICATE OF DEATH

Reg. Dist. No.

02944

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Villa Nova				c. LENGTH OF STAY IN 1b 5 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Augsburg Home				d. STREET ADDRESS 4908 Morella Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				3V01-4			
3. NAME OF DECEASED (Type or print) First Margaret Middle Greiner Last				4. DATE OF DEATH Month March Day 15 Year 60			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 31, 1871	
9. AGE (In years last birthday) 88 yrs.		10. UNDER 1 YEAR Months 88 Days 25 Hours 25 Min.		11. UNDER 24 HRS. Months 88 Days 25 Hours 25 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Baltimore Md.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME George Sack				14. MOTHER'S MAIDEN NAME Rau			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none			
INFORMANT Records Augsburg Home				Address 6811 Campfield Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture of left femur. (c) Generalized Arterio-sclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arterio-sclerosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Yes				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell.			
20c. TIME OF INJURY Month, Day, Year Hour Feb. 1960 p.m. 7:15				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) Augsburg Home				20f. (City or town) (County) (State) Baltimore - County - Md.			
21. I certify that I attended the deceased from Aug. 16, 1956 to March 15, 1960 , that I last saw the deceased alive on March 15, 1960 , and that death occurred at 4 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Earl L. Chambers				ADDRESS (Street, city or town, state) DATE SIGNED 4108 Liberty St. - Balto. - Md. - 3-15-60			
PHYSICIAN'S NAME (Type) Earl L. Chambers				4108 Liberty St. - Balto. - Md. -			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/60		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P.A. Heemann				ADDRESS 6067 Harford Rd.			
24a. REC'D BY REGISTRAR DATE MAR 21 '60				24b. REGISTRAR'S SIGNATURE Arthur E. Hume			

090

Approved 3-18-60 John C. Hyle, Md. Deputy Registrar - Baltimore

MEDICAL CERTIFICATION

1895

CERTIFICATE OF DEATH

2937

City of New York

Age 3 Yrs. 3 Mos.

Place of Birth

Residence

Date of Death

Place of Death

Signature of Doctor

Recorded and Indexed

Filed for Record

Witness

Signature of Registrar

Signature of Deputy Registrar

Signature of Health Officer

Signature of Coroner

Signature of Jury

Signature of Court

Signature of State

Signature of President

Signature of Vice President

1
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CP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
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CP

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2978
CERTIFICATE OF DEATH

02945

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 46 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1401 McCullough Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EARL Middle R. Last GROOMES, SR.		4. DATE OF DEATH Month March Day 14 Year 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1895
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 64 Days 14 Hours 19 Min. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Manufacturing Co.	
11. BIRTHPLACE (State or foreign country) Sykesville, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Nickolas Groomes		14. MOTHER'S MAIDEN NAME Betty Cook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 220-09-0578	
17. INFORMANT Clinical Records, VAH, Balto. 18, Md., Ft. Howard Div.		Address Clinical Records, VAH, Balto. 18, Md., Ft. Howard Div.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X THROMBOSIS OF THE MIDDLE CEREBRAL ARTERY, RIGHT SIDE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. XXXXX BILATERAL BRONCHOPNEUMONIA WITH ABSCESS FORMATION XXXXX SQUAMOUS CELL CARCINOMA OF THE TONGUE (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 WEEKS 2 YEARS		INTERVAL BETWEEN ONSET AND DEATH HOURS 2 WEEKS 2 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from January 28, 1960 to March 14, 1960 , that (b) (we) last saw the deceased alive on March 14, 1960 , and that death occurred at 1:45 AM on the causes and on the date stated above.			
22a. SIGNATURE Caridad E. Gonzalez 22c. PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M.D.		22b. DATE SIGNED 3/14/60 22d. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/17/60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		25a. REC'D BY REGISTRAR MAR 22 '60 25b. REGISTRAR'S SIGNATURE Charles S. Harris	

CERTIFICATE OF DEATH

2322

City and State

Deceased

Birth Date

Age

Sex

Place of Birth

Place of Death

Occupation

Color

Height

Weight

Complexion

Build

Marital Status

Order

Signature

Signature

230-00-0-70 Clinical Record, Vol. 1, Page 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

VAL. BATHING AND B. F. BATHING

VAL. BATHING AND B. F. BATHING

Baltimore National Bank, Baltimore, Maryland

Baltimore National Bank, Baltimore, Maryland

1900, 1901, 1902, 1903, 1904, 1905, 1906, 1907, 1908, 1909, 1910, 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000

Baltimore National Bank, Baltimore, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2979

CERTIFICATE OF DEATH

02946

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rosedale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7216 Pulaski Highway #6		d. STREET ADDRESS 7216 Pulaski Highway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PASQUALE First Middle Last GUIDO.		4. DATE OF DEATH March 11, 1960. Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1891 9. AGE (In years last birthday) 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Galvanizer		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co. 11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME GEIMARO GUIDO		14. MOTHER'S MAIDEN NAME MARIANTONNIA CANTALUPO.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. ----- 17. INFORMANT Anna H. Woppman Address Same.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO central vascular disease - sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular Disease (c) Unknown			INTERVAL BETWEEN ONSET AND DEATH 4 hours 9 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 27, 1951 , to 3/11 , 19 60 , that I last saw the deceased alive on 3/11 , 19 60 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Philibert Artigiani		ADDRESS (Street, city or town, state) 1305 Mayfield Ave. Balt. 13, Md. DATE SIGNED 3/12/60	
PHYSICIAN'S NAME (Type) Philibert Artigiani			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-14-60.	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) 7225 Eastern Blvd. Ba. Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Zeiler ADDRESS 901 S. CONKLING ST BALTO., MD.		24a. REC'D BY REGISTRAR DATE MAR 15 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, the certificate should be detached from the burial-transit permit. Then please remove carbon paper and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN	
10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF CORONER	
13. SIGNATURE OF JUDGE		14. SIGNATURE OF CLERK		15. SIGNATURE OF SHERIFF	
16. SIGNATURE OF DEPUTY SHERIFF		17. SIGNATURE OF CONSTABLE		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02947

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex (21)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Essex (21)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1804 Elk Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>KATHERINE</u> Middle <u>HAHN</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6, 1900</u>
9. AGE (In years last birthday) yrs. <u>59</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Schwalb</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Mahr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-07-3229</u>	
17. INFORMANT <u>John H. Hahn</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma left thigh</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>3 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Jan 1, 1960</u> to <u>March 1, 1960</u> , that I last saw the deceased alive on <u>March 1, 1960</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Baltimore Md</u> DATE SIGNED <u>3/4/60</u>			
ACTUAL SIGNATURE <u>J M Bannardine M.D.</u>		PHYSICIAN'S NAME (Type) _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/5/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore County Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Pruzdzinski</u>		ADDRESS <u>1407 Eastern Ave.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached from this as the burial-transit permit. Then please remove carbon-paper pages 3 and 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2981 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u> c. LENGTH OF STAY IN 1b <u>6 1/2 months</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 19, Maryland</u> d. STREET ADDRESS <u>529 Ea. Street.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Ryan</u> Last <u>Hancock</u>		4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/29/49</u>
9. AGE (In years lost birthday) <u>10</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Ritter Hancock</u>		14. MOTHER'S MAIDEN NAME <u>Lorna Jean Hunt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Rosewood Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonitis</u> <u>344.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Non-communicative Hydrocephalus</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24-hours</u> <u>Susp. since 4 yrs. of age</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/14/59</u> , 19____, to <u>3/9/60</u> , 19____, that I last saw the deceased alive on <u>3/9/60</u> , 19____, and that death occurred at <u>10:00a</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Pappas</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Resident Univ. of Md 3/9/60 Hospital</u>	
PHYSICIAN'S NAME (Type) <u>J. Pappas, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-12-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Eastern Ave. 24, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Duda</u>		ADDRESS <u>7922 Wise Avenue 22, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After certificate has been signed by the attending physician and completed, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1901

100-000

100-000

100-000

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100-000

100-000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2895

CERTIFICATE OF DEATH

02949

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22		c. LENGTH OF STAY IN TB 33 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1501 Bethlehem Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Baltimore 22	
f. STREET ADDRESS 1501 Bethlehem Ave.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BENJAMIN BROOKS HARRISON		4. DATE OF DEATH March 27, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1879
9. AGE (In years birthday) 80		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationery		10b. KIND OF BUSINESS OR INDUSTRY Power Plant	
11. BIRTHPLACE (State or foreign country) Oxford, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Franklin Harrison		14. MOTHER'S MAIDEN NAME Martha Jane Hunt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not, unknown) No		16. SOCIAL SECURITY NO. 220-22-0103	
17. INFORMANT Leonard R. Harrison - same as # 4		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis. DUE TO Cancer Prostate gland Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 6 mrs. 3 yrs. 3 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1, 1957 , to Mar 27, 1960 , that I last saw the deceased alive on Mar 26, 1960 , and that death occurred at 3:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 33 Dundalk Ave. DATE SIGNED 3/29/60 ACTUAL SIGNATURE David H. Andrew M.D. PHYSICIAN'S NAME (Type) David H. Andrew, M.D. Baltimore 22, Maryland			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF 3-30-60	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore County Md.
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc.		24a. REC'D BY REGISTRAR -Dundalk 22, Md.	24b. REGISTRAR'S SIGNATURE Charles S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached from the certificate as the burial-transit permit. Then please remove carbon paper and page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH Baltimore		PLACE OF DEATH Baltimore	
DISTRICT 38		DISTRICT 38	
STREET 1501 Washington Ave.		STREET 1501 Washington Ave.	
CITY Baltimore		CITY Baltimore	
STATE Maryland		STATE Maryland	
DATE OF BIRTH March 27, 1900		DATE OF DEATH April 10, 1900	
SEX Male		SEX Male	
OCCUPATION Stationary		OCCUPATION Stationary	
COUNTRY OF BIRTH USA		COUNTRY OF BIRTH USA	
NAME OF DECEASED Benjamin Franklin Harrison			
NAME OF NEXT OF KIN Nathan Lane Hunt			
ADDRESS OF NEXT OF KIN 1200 - 25-0101 Harrison - Lane at 4			
CAUSE OF DEATH (1) ... (2) ... (3) ...			
PLACE OF INTERMENT ...			
SIGNATURE OF PHYSICIAN ...			
SIGNATURE OF WITNESS ...			
DATE OF INTERMENT ...			
PLACE OF INTERMENT ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2982
CERTIFICATE OF DEATH

02950

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 13 3/4 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LEO Middle A. Last HARTMAN				4. DATE OF DEATH Month March Day 11 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/16/92	
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Brewery		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Alphonse Hartman				14. MOTHER'S MAIDEN NAME Margaret Biel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 216-05-4207		17. INFORMANT Clin. Records VAH, Bal to. 18, Md., Ft. Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL THROMBOSIS (c) EDEMA OF LUNGS				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that xx (this hospital) attended the deceased from 8:15 A.M. March 11, 1960 to 10:00 P.M. March 11, 1960 , that xx (we) last saw the deceased alive on March 11, 1960 , and that death occurred 10:00 P.M. from the causes and on the date stated above.				22b. DATE SIGNED			
22a. SIGNATURE JAMES R. POWDER, M.D.				22c. PHYSICIAN'S NAME (Type) JAMES R. POWDER, M.D.			
22d. ADDRESS VAH Ft. Howard, Maryland				22e. DATE 3/12/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-15-60		23c. NAME OF CEMETERY OR CREMATORY St. Stephens		23d. LOCATION (City, town, or county) (State) Bradshaw Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Blight, Inc., 6009 Harford Rd.				25a. REC'D BY REGISTRAR DATE MAR 15 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
WM. COOK-BLIGHT, INC., 6009 HARFORD RD., BALTO. 14, MD.							

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2983

CERTIFICATE OF DEATH

Reg. Dist. No.

02951

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison		c. LENGTH OF STAY IN lb 4 wks.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Foxleigh Nursing Home		d. STREET ADDRESS 2425 Diana Rd. #9	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOUI'S Middle HARTZ Last		4. DATE OF DEATH Month March Day 9 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1899
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Ladies Ready Wear	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Moses Hartz		14. MOTHER'S MAIDEN NAME Lena Sugar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Mrs. Miriam Hartz Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypernephroma with multiple metastases DUE TO 180X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary sclerosis			INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1942 , 19 3/9 , 19 60 , that I last saw the deceased alive on 3/8 , 19 60 , and that death occurred at 11A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Milton B. Kirsh, M.D. 2320 Eutaw Pl			
ACTUAL SIGNATURE		M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/10/60.	22c. NAME OF CEMETERY OR CREMATORY Hebrew Friendship	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Sol Levinson & Bros., Inc. 6010 Reist. Rd.		24a. REC'D BY REGISTRAR MAR 11 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Kirsh

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

• *could be*

Debra L. Davis, MD

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2984

CERTIFICATE OF DEATH

Reg. Dist. No. 4218

1. PLACE OF DEATH o. COUNTY <i>BALT, more</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MARYLAND</i> b. COUNTY <i>BALTIMORE</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PARKVILLE</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X PARKVILLE</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8907 Avondale Rd</i>		1. d. STREET ADDRESS <i>8907 Avondale Rd</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>MARY</i> Middle <i>H</i> Last <i>HAUCR</i>		4. DATE OF DEATH Month <i>MARCH</i> Day <i>31</i> Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>APRIL 18-1896</i>
9. AGE (In years last birthday) <i>63</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <i>HOUSE WIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>AT Home</i>	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>August Heuer</i>		14. MOTHER'S MAIDEN NAME <i>MARY Healy</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>HENRY L HAUCR</i> Address <i>Same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260X Myocardial degeneration</i> DUE TO (b) <i>Diabetes Mellitus c Gen'd</i> DUE TO (c) <i>Arteriosclerosis c Cardio Vase disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 mos</i> <i>6 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Partial Obstruction</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec</i> , 19 <i>57</i> to <i>Mar</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Apr 30</i> , 19 <i>60</i> , and that death occurred at <i>9:08</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank T. Kasik, Jr</i> M.D.		ADDRESS (Street, city or town, state) <i>Balto Md</i> DATE SIGNED <i>4/2/60</i>	
PHYSICIAN'S NAME (Type) <i>DR. FRANK T. KASIK, JR</i>		<i>9005 HARFORD RD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>4/4/1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>PARKWOOD</i>	22d. LOCATION (City, town, or county) (State) <i>BALT, more Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Chas. F. Evanson</i> ADDRESS <i>8802 Harford Rd</i>		24a. REC'D BY REGISTRAR DATE <i>APR 5 '60</i> 24b. REGISTRAR'S SIGNATURE <i>Clifford L. Evans</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the County Medical Examiner should execute the certificate, signing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the County Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Item 262 5-13-60 ans											
Item 7 Film G-261 4/13/60 1wk											
Item 64219											
MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH											
a. COUNTY Baltimore MARYLAND											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)											
c. LENGTH OF STAY IN 1b											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)											
Rt. 40 - Big Gunpowder Falls Road											
2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)											
a. STATE Maryland b. COUNTY Baltimore											
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)											
d. STREET ADDRESS											
Rt. 40 - Big Gunpowder Falls Rd.											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print)											
First IRENE Middle HAYNES Last HAYNES											
4. DATE OF DEATH											
Month March Day 28 Year 19 60											
5. SEX Female											
6. COLOR OR RACE Colored											
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
8. DATE OF BIRTH											
Mar 10 19 31											
9. AGE (In years last birthday) 36 yrs.											
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)											
10b. KIND OF BUSINESS OR INDUSTRY											
11. BIRTHPLACE (State or foreign country)											
Baltimore Md											
12. CITIZEN OF WHAT COUNTRY?											
13. FATHER'S NAME											
Bighouse Jackson											
14. MOTHER'S MAIDEN NAME											
Queenie Miller											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)											
16. SOCIAL SECURITY NO.											
17. INFORMANT Address											
Mrs. Elizabeth Murdock 244 Exeter St.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia											
493 X DUE TO											
Conditions, if any, which gave rise to immediate cause (b)											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year											
Hour e.m. p.m. 19											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											
DATE SIGNED											
3/29/60											
ACTUAL SIGNATURE Charles S. Petty											
EXAMINER'S NAME (Type) Charles S. Petty, M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify)											
Burial											
22b. DATE THEREOF											
3-10-60											
22c. NAME OF CEMETERY OR CREMATORY											
Mt. Auburn											
22d. LOCATION (City, town, or country) (State)											
Westport Md											
23. FUNERAL DIRECTOR ADDRESS											
Aolphus Halstead 918 Druid Hill Ave.											
24a. REC'D BY REGISTRAR											
DATE APR 11 '60											
24b. REGISTRAR'S SIGNATURE											
Arthur L. Kraw											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02952

2986

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	c. LENGTH OF STAY IN 1b <u>1 YR.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2924 EDGEWOOD AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM ALMON HAYS</u>		4. DATE OF DEATH <u>MARCH 24, 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 26, 1891</u>
9. AGE (In years lost birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MASSACHUSETTS</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>ALFRED WATSON HAYS</u>		14. MOTHER'S MAIDEN NAME <u>ALICE MAE KIFFE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Hq. Warren Hays 2924 Edgewood Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion & Infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Coronary artery disease</u> (c) <u>Arteriosclerosis and Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>57 yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1959</u> to <u>Mar 1960</u> , that I last saw the deceased alive on <u>May 24, 1960</u> and that death occurred at <u>10:07 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9005 Harford Rd Balto 14</u> DATE SIGNED <u>3/26/60</u> ACTUAL SIGNATURE <u>Frank T. Kasik, Jr.</u> M.D. PHYSICIAN'S NAME (Type) <u>FRANK T. KASIK Balto 14</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/28/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO., MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Montley Miller, 2334</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 28 '60</u>	
ADDRESS <u>Jefferson St.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	

2987

CERTIFICATE OF DEATH

02953

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. LENGTH OF STAY IN b <u>5 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2952 MANNS Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A</u> Last <u>Healy</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 16-1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HAT CO.</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PATRICK Healy</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET Cronin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>189-18-166A</u>	
17. INFORMANT <u>JAMES F Healy</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Coronary Artery disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with coronary occlusion</u> DUE TO (c) <u>Generalized Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4+ yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART-I (a) <u>Multiple: Cerebro-vascular thrombi & Vertigo</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1958</u> to <u>Present</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Mar 18</u> 19 <u>60</u> ; and that death occurred at <u>5:00 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T. Kasikur</u>		M.D. <u>9005 HARTFORD RD</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T KASIKUR</u>		<u>BALTO 14 MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/22-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS F. EVANS & Son</u>		ADDRESS <u>8802 Hartford Rd</u>	
24a. REC'D BY REGISTRAR <u>MAR 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached from this page as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10055

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF PHYSICIAN</p>	
<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF WITNESS</p>		<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF NEXT OF KIN</p>	
<p>17. SIGNATURE OF CLERK</p>		<p>18. SIGNATURE OF CHIEF CLERK</p>		<p>19. SIGNATURE OF ASSISTANT CLERK</p>		<p>20. SIGNATURE OF DEPUTY CLERK</p>	
<p>21. SIGNATURE OF DEPUTY CLERK</p>		<p>22. SIGNATURE OF DEPUTY CLERK</p>		<p>23. SIGNATURE OF DEPUTY CLERK</p>		<p>24. SIGNATURE OF DEPUTY CLERK</p>	
<p>25. SIGNATURE OF DEPUTY CLERK</p>		<p>26. SIGNATURE OF DEPUTY CLERK</p>		<p>27. SIGNATURE OF DEPUTY CLERK</p>		<p>28. SIGNATURE OF DEPUTY CLERK</p>	
<p>29. SIGNATURE OF DEPUTY CLERK</p>		<p>30. SIGNATURE OF DEPUTY CLERK</p>		<p>31. SIGNATURE OF DEPUTY CLERK</p>		<p>32. SIGNATURE OF DEPUTY CLERK</p>	
<p>33. SIGNATURE OF DEPUTY CLERK</p>		<p>34. SIGNATURE OF DEPUTY CLERK</p>		<p>35. SIGNATURE OF DEPUTY CLERK</p>		<p>36. SIGNATURE OF DEPUTY CLERK</p>	
<p>37. SIGNATURE OF DEPUTY CLERK</p>		<p>38. SIGNATURE OF DEPUTY CLERK</p>		<p>39. SIGNATURE OF DEPUTY CLERK</p>		<p>40. SIGNATURE OF DEPUTY CLERK</p>	
<p>41. SIGNATURE OF DEPUTY CLERK</p>		<p>42. SIGNATURE OF DEPUTY CLERK</p>		<p>43. SIGNATURE OF DEPUTY CLERK</p>		<p>44. SIGNATURE OF DEPUTY CLERK</p>	
<p>45. SIGNATURE OF DEPUTY CLERK</p>		<p>46. SIGNATURE OF DEPUTY CLERK</p>		<p>47. SIGNATURE OF DEPUTY CLERK</p>		<p>48. SIGNATURE OF DEPUTY CLERK</p>	
<p>49. SIGNATURE OF DEPUTY CLERK</p>		<p>50. SIGNATURE OF DEPUTY CLERK</p>		<p>51. SIGNATURE OF DEPUTY CLERK</p>		<p>52. SIGNATURE OF DEPUTY CLERK</p>	
<p>53. SIGNATURE OF DEPUTY CLERK</p>		<p>54. SIGNATURE OF DEPUTY CLERK</p>		<p>55. SIGNATURE OF DEPUTY CLERK</p>		<p>56. SIGNATURE OF DEPUTY CLERK</p>	
<p>57. SIGNATURE OF DEPUTY CLERK</p>		<p>58. SIGNATURE OF DEPUTY CLERK</p>		<p>59. SIGNATURE OF DEPUTY CLERK</p>		<p>60. SIGNATURE OF DEPUTY CLERK</p>	
<p>61. SIGNATURE OF DEPUTY CLERK</p>		<p>62. SIGNATURE OF DEPUTY CLERK</p>		<p>63. SIGNATURE OF DEPUTY CLERK</p>		<p>64. SIGNATURE OF DEPUTY CLERK</p>	
<p>65. SIGNATURE OF DEPUTY CLERK</p>		<p>66. SIGNATURE OF DEPUTY CLERK</p>		<p>67. SIGNATURE OF DEPUTY CLERK</p>		<p>68. SIGNATURE OF DEPUTY CLERK</p>	
<p>69. SIGNATURE OF DEPUTY CLERK</p>		<p>70. SIGNATURE OF DEPUTY CLERK</p>		<p>71. SIGNATURE OF DEPUTY CLERK</p>		<p>72. SIGNATURE OF DEPUTY CLERK</p>	
<p>73. SIGNATURE OF DEPUTY CLERK</p>		<p>74. SIGNATURE OF DEPUTY CLERK</p>		<p>75. SIGNATURE OF DEPUTY CLERK</p>		<p>76. SIGNATURE OF DEPUTY CLERK</p>	
<p>77. SIGNATURE OF DEPUTY CLERK</p>		<p>78. SIGNATURE OF DEPUTY CLERK</p>		<p>79. SIGNATURE OF DEPUTY CLERK</p>		<p>80. SIGNATURE OF DEPUTY CLERK</p>	
<p>81. SIGNATURE OF DEPUTY CLERK</p>		<p>82. SIGNATURE OF DEPUTY CLERK</p>		<p>83. SIGNATURE OF DEPUTY CLERK</p>		<p>84. SIGNATURE OF DEPUTY CLERK</p>	
<p>85. SIGNATURE OF DEPUTY CLERK</p>		<p>86. SIGNATURE OF DEPUTY CLERK</p>		<p>87. SIGNATURE OF DEPUTY CLERK</p>		<p>88. SIGNATURE OF DEPUTY CLERK</p>	
<p>89. SIGNATURE OF DEPUTY CLERK</p>		<p>90. SIGNATURE OF DEPUTY CLERK</p>		<p>91. SIGNATURE OF DEPUTY CLERK</p>		<p>92. SIGNATURE OF DEPUTY CLERK</p>	
<p>93. SIGNATURE OF DEPUTY CLERK</p>		<p>94. SIGNATURE OF DEPUTY CLERK</p>		<p>95. SIGNATURE OF DEPUTY CLERK</p>		<p>96. SIGNATURE OF DEPUTY CLERK</p>	
<p>97. SIGNATURE OF DEPUTY CLERK</p>		<p>98. SIGNATURE OF DEPUTY CLERK</p>		<p>99. SIGNATURE OF DEPUTY CLERK</p>		<p>100. SIGNATURE OF DEPUTY CLERK</p>	



10

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached from the certificate as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02954

2988 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 52 Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4 Payson Ave.				d. STREET ADDRESS 4 Payson Ave.			
3. NAME OF DECEASED (Type or print) Mary R. Hefner				4. DATE OF DEATH Month March Day 9 Year 1960			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1886		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME John Gribbin				14. MOTHER'S MAIDEN NAME Anna Knell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -- (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. --		17. INFORMANT Mr. Louis G. Hefner Address 4 Payson Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Artericular Decompensation (c) Hypertension INTERVAL BETWEEN ONSET AND DEATH 12 hr. 4 mos. 2 yrs?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3.4 , 19 57 , to 3.9 , 19 60 , that I last saw the deceased alive on 3.8 , 19 60 , and that death occurred at 3.4 M., from the causes and on the date stated above.							
ACTUAL SIGNATURE George E. Urban				ADDRESS (Street, city or town, state) 805 Frederick Ave Md DATE SIGNED 3.9.60			
PHYSICIAN'S NAME (Type) George E. URBAN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-60		22c. NAME OF CEMETERY OR CREMATORY Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home				ADDRESS Catonsville, Md.		24a. REC'D BY REGISTRAR DATE MAR 11 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

STATE OF CALIFORNIA—DEPARTMENT OF HEALTH—BIRMINGHAM, ALA.

2989

CERTIFICATE OF DEATH

02955

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN lb 58 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MT. DE SALES ACADEMY		d. STREET ADDRESS MT. DE SALES ACADEMY	
3. NAME OF DECEASED (Type or print) First Middle Last SISTER MARY CLEOPHAS HENNESSY		4. DATE OF DEATH Month Day Year MARCH 10, 1960.	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 10, 1871.
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SISTER		10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS	
11. BIRTHPLACE (State or foreign country) IRELAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS HENNESSY		14. MOTHER'S MAIDEN NAME ELIZABETH DOYLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
INFORMANT MT. DE SALES ACADEMY,		Address CATONSVILLE 28, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 15, 1960 , to MARCH 10, 1960 , that I last saw the deceased alive on MARCH 10, 1960 , and that death occurred at 11:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Dario Ugarte M.D. 3603 Edmonson AVE. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) DARIO UGARTE BALTIMORE 29, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH 12, 1960	
22c. NAME OF CEMETERY OR CREMATORY MT. DESALES CEMETERY		22d. LOCATION (City, town, or county) (State) CATONSVILLE, 28, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons, Catonsville 28, Md.		24a. REC'D BY REGISTRAR DATE MAR 17 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1508

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1508

Blank certificate form with horizontal lines for text entry.



1 8 02956 2990 CERTIFICATE OF DEATH Reg. Dist. No. 32 1 002 1 2 1 VS A15 (4) 15M 10/57

2990 CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 15-56-2		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 10707 Edgewood Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle HERMANN Last HERMANN		4. DATE OF DEATH Month 3- Day 3- Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-21-76
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 84	11. IF UNDER 24 HRS. Days 84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) THEATRE MANAGER		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) CZECHOSLOVAKIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PETER HERMANN		14. MOTHER'S MAIDEN NAME ANNA KLEIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT Hospital records, Mt. Wilson State Hospital		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from 2-17 , 19 60 , to 3-3 , 19 60 , that I last saw the deceased alive on 3-3 , 19 60 , and that death occurred at 11 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED —			
ACTUAL SIGNATURE Wm. Newcomer M.D. Superintendent			
PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH 6, 1960	
22c. NAME OF CEMETERY OR CREMATORY NEW MT. CARMEL CEMETERY		22d. LOCATION (City, town, or county) (State) BROOKLYN NY	
23. FUNERAL DIRECTOR'S SIGNATURE B. Kozaneky & Sons		24a. REC'D BY REGISTRAR DAIR 8 '60	
ADDRESS 3501-14 ST. N.W.		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, the certificate should be detached from the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1944

5/11/14

2. Training

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled out, page 5 should be detached from the certificate and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02957

2991

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY Balt	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson		c. LENGTH OF STAY IN 1b 5 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood Sanatorium Towson 4, Maryland		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5 Catonsville	
3. NAME OF DECEASED (Type or print) First JAMES Middle BOSLEY Last HILL		4. DATE OF DEATH Month 3 Day 4 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/18/83
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR: Months 7 Days 15 Hours 10 Min 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired B & O R.R.		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Balt Md		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Wm J Hill		14. MOTHER'S MAIDEN NAME Ellen Bell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 705-05-4962	
17. INFORMANT Personal History		Address Hospital Records, Eudowood Sanatorium	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) / DUE TO (c) /		INTERVAL BETWEEN ONSET AND DEATH 5 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus - Carcinoma Cervix removed 7/58		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 15 , 19 59 , to March 4 , 19 60 , that I last saw the deceased alive on March 3 , 19 60 , and that death occurred at 10:15 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Milton B. Kress		ADDRESS (Street, city or town, state) Eudowood Sanatorium - Towson 4, Md.	
DATE SIGNED MAR 7 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kress	
PHYSICIAN'S NAME (Type) Milton B. Kress, M.D.		24a. REC'D BY REGISTRAR MAR 7 '60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-7-1960	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet		22d. LOCATION (City, town, or county) (State) Baltimore - Md	
23. FUNERAL DIRECTOR'S SIGNATURE MacRatt & Son		ADDRESS (28)	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2910

CERTIFICATE OF DEATH

Reg. Dist. No.

02958

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown</i>	c. LENGTH OF STAY IN 1b <i>6 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>230 main St</i>		e. STREET ADDRESS <i>1230 main St</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Eugenia</i> Last <i>Hilton</i>		4. DATE OF DEATH Month <i>March</i> Day <i>12</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 29, 1872</i>
9. AGE (In years last birthday) <i>87 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Josiah Ritter</i>	
14. MOTHER'S MAIDEN NAME <i>Emma J. Hooper</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>J. Wilhelm Hilton</i> Address <i>718 Belknap Ave Baltimore City</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> <i>334X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Senility</i> DUE TO (c) <i>Cerebral Arteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>March 8, 1960</i> to <i>March 12, 1960</i> that I last saw the deceased alive on <i>March 12, 1960</i> , and that death occurred at <i>3:00</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George C. Medairy</i> M.D.		ADDRESS (Street, city or town, state) <i>230 main St.</i>	
PHYSICIAN'S NAME (Type) <i>George C. Medairy M.D.</i>		DATE SIGNED <i>Reisterstown Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>March 15, 60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>All Saints Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Reisterstown, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.F.Eline & Sons</i> ADDRESS <i>Reisterstown, Md.</i>		24a. REC'D BY REGISTRAR <i>DATE MAR 15 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Charles J. Kraus</i>

CERTIFICATE OF DEATH

1922



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2992

CERTIFICATE OF DEATH

02953

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PERRY HALL</u>				c. LENGTH OF STAY IN 1b <u>30 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4041 WALTER AVE.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>G.</u> Last <u>HOFFSTETTER</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 1, 1879</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>GEORGE HOFFSTETTER</u>				14. MOTHER'S MAIDEN NAME <u>MARY E GUNTER.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>AUGUST HOFFSTETTER</u>				Address <u>4041 WALTER AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate c</u> <u>420.0</u> DUE TO <u>metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic Heart Disease</u> (c) <u>hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>den</u> <u>arteriosclerotic</u> INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 1, 1955</u> , to <u>Mar 12, 1960</u> , that I last saw the deceased alive on <u>Mar 11, 1960</u> , and that death occurred at <u>4:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald W. Mintzer</u>				ADDRESS (Street, city or town, state) <u>3029 E verges Ave Baltimore 14 Md</u>			
DATE SIGNED <u>3/14/60</u>							
PHYSICIAN'S NAME (Type) <u>DONALD W. MINTZER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/14/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louise F. Fernald</u>				ADDRESS <u>7401 Belair Rd #2</u>		24a. REC'D BY REGISTRAR <u>MAR 16 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fernald</u>							

STATE OF NEW YORK
CERTIFICATE OF DEATH

1900

CHIEF CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the registrar, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2993

CERTIFICATE OF DEATH

02960

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HILDA</u> Middle <u>HOIME</u> Last <u>Mar.</u>				4. DATE OF DEATH Month <u>6</u> Day <u>19</u> Year <u>60</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1888</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>60</u>	IF UNDER 24 HRS. Months <u>6</u> Days <u>19</u> Hours <u>60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never worked</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>			
11. BIRTHPLACE (State or foreign country) <u>N. J.</u>				12. CITIZEN OF WHAT COUNTRY? <u>N. J.</u>			
13. FATHER'S NAME <u>Henry Holme</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Waddington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>Mr. D. H. Waddington - Atlanta, Ga.</u>			
17. INFORMANT <u>Mr. D. H. Waddington - Atlanta, Ga.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of the uterus with wide spread metastases</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</u>				20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>20f. (City or town)</u> (County) (State)			
21. I certify that I attended the deceased from <u>Mar 4</u> , 19 <u>60</u> , to <u>death</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Mar 4</u> , 19 <u>60</u> , and that death occurred at <u>8:40 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest C Brown Jr.</u> M.D. <u>1101 N. Calvert St., Balt-2 Md</u>				DATE SIGNED <u>3/9/60</u>			
PHYSICIAN'S NAME (Type) <u>Ernest C Brown Jr.</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>3/9/60</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Friends Burial Ground</u>			
22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 8 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Wm. S. Thoma</u>				24c. REGISTRAR'S SIGNATURE <u>Wm. S. Thoma</u>			

1

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 2994
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

02961

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE NEW YORK b. COUNTY BUFFALO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 74				c. LENGTH OF STAY IN 1b 6 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7903 EASTDALE RD.				d. STREET ADDRESS 148 HOYT ST (7903 EASTDALE RD)			
3. NAME OF DECEASED (Type or print) GEORGIA C. HOLMES				4. DATE OF DEATH 3 - 27 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-3-1884	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ASSEMBLY LINE				10b. KIND OF BUSINESS OR INDUSTRY BELL AIR CRAFT		11. BIRTHPLACE (State or foreign country) BUFFALO	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CARR				14. MOTHER'S MAIDEN NAME HARRIET DAVIDSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 111-14084		17. INFORMANT MRS EVELYN HAMBLETON Address 7903 EASTDALE RD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Hypertensive Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 16 1960 to March 15 1960, that (I) last saw the deceased alive on March 15 1960, and that death occurred at 11 PM , from the causes and on the date stated above.							
22a. SIGNATURE Manuel P. de Leon				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) MANUEL P. DE LEON M.D.	
22d. ADDRESS 7840 Eastern Ave. Apt. 24, Md.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-31-1960		23c. NAME OF CEMETERY OR CREMATORIUM ELMLAWN		23d. LOCATION (City, town, or county) (State) BUFFALO NEW YORK	
24. FUNERAL DIRECTOR'S SIGNATURE J. Galley Conklin ADDRESS 5444 BELAIR RD. BUFFALO N.Y.				25a. REC'D BY REGISTRAR DATE MAR 30 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF BIRTH

New York

State of

County of

City of

1903

GEORGE C.

WILLIAMS

1903

George C.

Williams

born

1903

1903

1903

1903

1903

1903

2995

CERTIFICATE OF DEATH

Reg. Dist. No.

02962

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>		c. LENGTH OF STAY IN 1b <i>40 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville 8, MD.</i>	
		f. STREET ADDRESS <i>719 Cliveden Road</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>MARY HEAVER Horsey</i>		4. DATE OF DEATH Month Day Year <i>March 26 1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/11/1880</i>
9. AGE (In years last birthday) <i>79</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife own home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Pathol. M.D.</i>	
11. BIRTHPLACE (State or foreign country) <i>U. S. A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John Frederick Heaver</i>		14. MOTHER'S MAIDEN NAME <i>Louise B. Baran</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>M. Randolph Horsey</i>		Address <i>719 Cliveden Rd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of cervix of uterus</i> DUE TO (b) <i>171X</i> DUE TO (c) <i>Conditiions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>16 yrs</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec</i> , 19 <i>52</i> to <i>26 March</i> 19 <i>60</i> , that I last saw the deceased alive on <i>26 March</i> , 19 <i>60</i> , and that death occurred at <i>3:30 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Paul H Royse</i>		ADDRESS (Street, city or town, state) <i>808 Reisterstown Rd</i> DATE SIGNED <i>26 Mar 60</i>	
PHYSICIAN'S NAME (Type) <i>PAUL H Royse</i>		<i>Pikesville 8 Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>March 28, 1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Wood Ridge Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Pikesville, 8 MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank H. Hend</i>		ADDRESS <i>Pikesville 8, MD.</i>	
24a. REC'D BY REGISTRAR <i>MAR 29 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>	

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2896

CERTIFICATE OF DEATH

Reg. Dist. No.

02963

1. PLACE OF DEATH a. COUNTY <u>Dundalk Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dundalk Baltimore County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Turner Station</u>		c. LENGTH OF STAY IN 1b <u>53</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>213 Center Street</u>		d. STREET ADDRESS <u>213 Center Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Nannie</u> Middle <u>F.</u> Last <u>Hurley</u>		4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1900</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Warrington, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Grant</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ella Cooper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Marshall Hurley - 213 Center Street</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>156.1</u> DUE TO <u>Hepatic Carcinoma -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 1959</u> to <u>March 1960</u> that I last saw the deceased alive on <u>March 10/60</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Thomas</u>		DATE SIGNED <u>10-7-71 Main St. Balto 22</u>	
PHYSICIAN'S NAME (Type) <u>J. Thomas</u>		<u>10771 Main St. Balto 22</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-15-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Baptist</u>	22d. LOCATION (City, town, or county) (State) <u>Warrington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. Lew</u>		ADDRESS <u>802 Madison Avenue</u>	
24a. REC'D BY REGISTRAR <u>MAR 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Lew</u>	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1900		Boston, Mass.	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Roman Catholic	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
Jan 15, 1945		10:30 AM		Home		Dr. Smith		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]		[Seal]		[Seal]	
Date of Issuance		Time of Issuance		Place of Issuance		Physician		Hospital	
Jan 16, 1945		11:00 AM		Home		Dr. Smith		St. Mary's	

2996

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3mth2dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marilyn Middle May Last Johnson				4. DATE OF DEATH Month March Day 24 Year 19 60			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 28, 1925	
9. AGE (In years last birthday) 34 yrs.		10. IF UNDER 1 YEAR Months 34 Days 34 Hours 34 Min.		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Charles James				14. MOTHER'S MAIDEN NAME Gladys Goldlust			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diffuse bronchopneumonia DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 18, 19 60 to March 24, 19 60 that I last saw the deceased alive on March 24, 19 60 , and that death occurred at 1:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				DATE SIGNED 3-24-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) 3/28/60				22c. NAME OF CEMETERY OR CREMATORY FOREST LAWN			
22b. DATE THEREOF				22d. LOCATION (City, town, or county) (State) BOARTMAN, OHIO			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph F. Binch, Son - 3034 M St. N.W.				24a. REC'D BY REGISTRAR DATE MAR 29 '60			
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

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in by the funeral director. After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02965

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 23 MONTHS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME				d. STREET ADDRESS 5206 FERN PARK AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILBUR E JOHNSON				4. DATE OF DEATH Month Day Year MARCH 13 1960			
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-8-1889		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONDUCTOR		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GEORGE W. JOHNSON				14. MOTHER'S MAIDEN NAME AMELIA WITTMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 709-10-5339		17. INFORMANT Address Frank L. Smith Jr. - Cockeysville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior Atherosclerotic Cardiac 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Vascular Disease DUE TO (c) 2 years							INTERVAL BETWEEN ONSET AND DEATH 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-16 19 56 to 3-13 19 60 , that (I) (we) last saw the deceased alive on 3-13 19 60 , and that death occurred at 6208 M, from the causes and on the date stated above.							
22a. SIGNATURE Walter T. Kees				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/13/60	
22c. PHYSICIAN'S NAME (Type) WALTER T KEES				22d. ADDRESS COCKEYSVILLE, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-15-60		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) (State) Woodland, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street				25a. REC'D BY REGISTRAR DATE MAR 15 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Harris	

BP

CERTIFICATE OF DEATH

1937

1. Name of deceased: [illegible]

2. Date of death: [illegible]

3. Place of death: [illegible]

4. Cause of death: [illegible]

5. Name of physician: [illegible]

6. Name of funeral home: [illegible]

7. Name of informant: [illegible]

8. Name of registrar: [illegible]

9. Name of registrar: [illegible]

10. Name of registrar: [illegible]

11. Name of registrar: [illegible]

12. Name of registrar: [illegible]

13. Name of registrar: [illegible]

14. Name of registrar: [illegible]

15. Name of registrar: [illegible]

16. Name of registrar: [illegible]

17. Name of registrar: [illegible]

18. Name of registrar: [illegible]

19. Name of registrar: [illegible]

20. Name of registrar: [illegible]

2897

CERTIFICATE OF DEATH

Reg. Dist. No.

02966

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Turners Sta</u>	c. LENGTH OF STAY IN 1b <u>30 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Turners Station</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1103 Walnut Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Dones</u> Last <u>Dones</u>		4. DATE OF DEATH Month <u>March</u> Day <u>13th</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7th 1901</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Mickey</u>		14. MOTHER'S MAIDEN NAME <u>Martha Fife</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Harvey Jones</u>		Address <u>103 Walnut</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>unknown</u> INTERVAL BETWEEN ONSET AND DEATH <u>about 1 yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 14th 1960</u> to <u>March 15th 1960</u> , that I last saw the deceased alive on <u>March 12th 1960</u> , and that death occurred at <u>12:15 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. J. Thomas</u> M.D.		ADDRESS (Street, city or town, state) <u>107 N. Main St. Baltimore 22, Md</u>	
PHYSICIAN'S NAME (Type) <u>J. J. Thomas</u>		DATE SIGNED <u>2/23/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	22b. DATE THEREOF <u>3-17-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Johnson</u> ADDRESS <u>1011-13 N. Arlington Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 15 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached from the certificate and taken to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

02967

2998

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium	
c. LENGTH OF STAY IN 1b unknown		d. STREET ADDRESS 8 Crowther Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 Crowther Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hugh Middle Jones Last		4. DATE OF DEATH Month 3 Day 9 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-21-1882
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 7 Days 8 Hours 10 Min.	11. IF UNDER 24 HRS. Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) stone mason		10b. KIND OF BUSINESS OR INDUSTRY contracting	
11. BIRTHPLACE (State or foreign country) Great Britain		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Wm. M. Jones, 1107 Echo St. S., Towson 4, Md.		Address N Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiac Disease DUE TO (c) Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 50 hr 10 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1948 to March 1960 that I last saw the deceased alive on March 9, 1960 , and that death occurred at 6:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7501 York Rd, Towson 4, Md. DATE SIGNED 3/10/60			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-60	
22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		22d. LOCATION (City, town, or county) (State) Baltimore 14, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.		24a. REC'D BY REGISTRAR DATE MAR 14 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

1958

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

8 Cromwell Ave.

8 Cromwell Ave.

Black Jones

1-21-1955

White Jones

Great Britain

congestive

congestive

unknown

unknown

Mr. K. Jones, 1107 Echo St. S., Townsville

Baltimore 46, Md.

Maryland Hospital

2-12-60

Brooks Funeral Service, Townsville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02968
32

2999

1. PLACE OF DEATH o. COUNTY Baltimore County		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland	c. LENGTH OF STAY IN 1b 15 1/2 mo.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 VO 1.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 3809 Birchview Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Lola Middle C. Last Jones		4. DATE OF DEATH Month 3 Day 22 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/4/95
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 74 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME W. Edward Reese	
14. MOTHER'S MAIDEN NAME Margaret A. Lawrence		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. —		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far Advanced Pulmonary Tuberculosis 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/9 , 19 58 , to 3/22 , 19 60 , that I last saw the deceased alive on 3/22 , 19 60 , and that death occurred at 5:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED ACTUAL SIGNATURE Wm. Newcomer M.D. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 3-25-60	22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		24a. REC'D BY REGISTRAR MAR 24 '60	24b. REGISTRAR'S SIGNATURE Carling S. K...

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02969

3000

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER	c. LENGTH OF STAY IN 1b —	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE #6	3 Vol. 4
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GLEN L. MARTINS Co.		d. STREET ADDRESS 4838 TRUESDALE AVE	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ROBERT	First L. Middle KABLE Last	4. DATE OF DEATH Month MARCH Day 3 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 6 1901
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRODUCTION WORKER		10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT	11. BIRTHPLACE (State or foreign country) BALTIMORE
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CLARENCE C. KABLE		14. MOTHER'S MAIDEN NAME IDA MAY MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT MRS CAROLYN J. KABLE		Address 4838 TRUESDALE AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASCV Disease DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M. B. DAVIS MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 4/4/60			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/7/60	22c. NAME OF CEMETERY OR CREMATORY WESTERN CEM	22d. LOCATION (City, town, or county) (State) BALTIMORE MD.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Vickner & Sons - Balt		24a. REC'D BY REGISTRAR DATE MAR 7 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
4. This certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5
TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
4. This certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5
TO FUNERAL DIRECTOR: Page 4 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
DEPT. OF HEALTH

7000

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____
AGE _____ SEX _____
DATE OF DEATH _____
PLACE OF DEATH _____

CAUSE OF DEATH _____
MANNER OF DEATH _____

DATE OF EXAMINATION _____
PLACE OF EXAMINATION _____

NAME OF PHYSICIAN _____
ADDRESS _____

SIGNATURE OF PHYSICIAN _____
TITLE _____

SIGNATURE OF MEDICAL EXAMINER _____
TITLE _____

DATE OF EXAMINATION _____
PLACE OF EXAMINATION _____

NAME OF PHYSICIAN _____
ADDRESS _____

SIGNATURE OF PHYSICIAN _____
TITLE _____

SIGNATURE OF MEDICAL EXAMINER _____
TITLE _____

DATE OF EXAMINATION _____
PLACE OF EXAMINATION _____

NAME OF PHYSICIAN _____
ADDRESS _____

SIGNATURE OF PHYSICIAN _____
TITLE _____

SIGNATURE OF MEDICAL EXAMINER _____
TITLE _____

DATE OF EXAMINATION _____
PLACE OF EXAMINATION _____

NAME OF PHYSICIAN _____
ADDRESS _____

SIGNATURE OF PHYSICIAN _____
TITLE _____

SIGNATURE OF MEDICAL EXAMINER _____
TITLE _____

DATE OF EXAMINATION _____
PLACE OF EXAMINATION _____

NAME OF PHYSICIAN _____
ADDRESS _____

SIGNATURE OF PHYSICIAN _____
TITLE _____

SIGNATURE OF MEDICAL EXAMINER _____
TITLE _____

DATE OF EXAMINATION _____
PLACE OF EXAMINATION _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 6 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

3001

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02970

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8204 Spring Bottom Way				d. STREET ADDRESS 8204 Spring Bottom Way			
3. NAME OF DECEASED (Type or print) First LOUIS Middle Last KADIS				4. DATE OF DEATH Month March Day 14 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 15, 1906	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY C.P.A.		11. BIRTHPLACE (State or foreign country) Durham, N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bernard Jacob Kadis				14. MOTHER'S MAIDEN NAME Rebecca Gertrude ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 216-53-7922		17. INFORMANT Ms Lora Kadis - 8304 Spring Bottom Way			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Russell S. Fisher, M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				DATE SIGNED 3/14/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 16 1960		22c. NAME OF CEMETERY OR CREMATORY Chizak Ameno		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Sol Kerner & Sons - 6010 Reisterstown Road				24a. REC'D BY REGISTRAR DATE MAR 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 13

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3002

CERTIFICATE OF DEATH

Reg. Dist. No.

02971

1. PLACE OF DEATH o. COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>over 5 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>600 Reisterstown Rd.</u>		d. STREET ADDRESS <u>600 Reisterstown Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>WILLIAM</u> Last <u>Kahl</u>		4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 30, 1885</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS, OR INDUSTRY, OR BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Kahl</u>		14. MOTHER'S MAIDEN NAME <u>Christina Weiss</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-12-0070</u>	
17. INFORMANT <u>Mrs. Edna A. Kahl</u>		Address <u>600 Reisterstown Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>13 Oct</u> , 19 <u>54</u> , to <u>March 23</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>27 Nov.</u> , 19 <u>59</u> , and that death occurred at <u>5 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Chee Randol</u> M.D.			
PHYSICIAN'S NAME (Type) <u>C. Lee Randol</u>		<u>Pikesville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 26, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Randon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		ADDRESS <u>Pikesville, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

Full name of deceased
Maryland
Place of birth
Date of birth
Date of death
Cause of death

Signature of physician
Signature of registrar
Signature of informant
Date of death
Place of death

Signature of registrar
Signature of informant
Date of death
Place of death
Signature of registrar
Signature of informant
Date of death
Place of death

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02972

3003 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 2yr3mth18dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gilbert Middle E. Last Kanour				4. DATE OF DEATH Month March Day 14 Year 1960			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1893	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) engineer Writer				10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME George Kanour			
14. MOTHER'S MAIDEN NAME Georgia PATTERSON				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) 1917-19			
16. SOCIAL SECURITY NO. 213-03-3097				INFORMANT Records, SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of the liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 2 , 1960, to March 14 , 1960 that I last saw the deceased alive on March 14 , 1960, and that death occurred at 10.15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 3-15-60							
ACTUAL SIGNATURE Stella Wachslar		M.D. SPRING GROVE STATE HOSPITAL					
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF March 18-1960		22c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cent		22d. LOCATION (City, town, or county) (State) Prince Georges Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Groszowski				ADDRESS Annapolis, Md		24a. REC'D BY REGISTRAR DATE MAR 22 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

3003

M

1

FOOT MEASUREMENT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02973

3004

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balt.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3705 Essex Rd.</u> c. LENGTH OF STAY IN 1b <u>4 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balt 7</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balt.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balt 7</u> d. STREET ADDRESS <u>3705 Essex Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>KASTENDIKE</u> Middle <u>LAST</u> Last		4. DATE OF DEATH Month <u>Mar</u> Day <u>17</u> Year <u>1960</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb-14, 1897</u>		9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Mln. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Promotion</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Crown Cork & Seal</u>		11. BIRTHPLACE (State or foreign country) <u>Brooklyn, N.Y.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>John Kastendike</u> 14. MOTHER'S MAIDEN NAME <u>Francis Jones</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes World War I</u>		16. SOCIAL SECURITY NO. <u>213-01-0124</u>		17. INFORMANT <u>Chas. W. Brasse Jr (Son-in-law)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Angina Pectoris</u> <u>420.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive C-V Disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>none</u> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>none</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>			
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <u>D. D. Caples</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-17-60</u>			
EXAMINER'S NAME (Type) <u>D. D. CAPLES</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>3/21/60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u> 22d. LOCATION (City, town, or county) <u>Pikesville, Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickner & Sons - Balt 17</u> ADDRESS _____		24a. REC'D BY REGISTRAR <u>MAR 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 6 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

3005 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>55 Towson</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1667 Thetford Rd.</i>		d. STREET ADDRESS <i>1667 Thetford Rd</i>	
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>A. Kavanagh</i> Last		4. DATE OF DEATH Month <i>March</i> Day <i>7</i> Year <i>19 60</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 7, 1908</i>
9. AGE (In years lost birthday) yrs. <i>51</i>		10. IF UNDER 1 YEAR Months Days Hours Min. <i>51</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Glenn L. Martin</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Kavanagh</i>		14. MOTHER'S MAIDEN NAME <i>Grace Wilson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Pauline Kavanagh</i> Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Myeloma, generalized</i> 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>15 mo ±</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>9/3/59</i> , 19____, to <i>3/7/60</i> , 19____, that I last saw the deceased alive on <i>3/7/60</i> , 19____, and that death occurred on <i>10:10 p M</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. M. Conway</i> M.D.		ADDRESS (Street, city or town, state) <i>8358 Loch Raven Blvd</i> DATE SIGNED <i>3/8/60</i>	
PHYSICIAN'S NAME (Type) <i>W. M. Conway M.D.</i>		<i>Towson 4, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>3-10-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Rd.</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 9 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

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15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3005 CERTIFICATE OF DEATH



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3006 **CERTIFICATE OF DEATH**

02975

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 11 Hours 25 M.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 113 Padonia Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES		First Middle Last E. KEENER		4. DATE OF DEATH Month March Day 2 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 30, 1891		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Printing Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Dashield Keener				14. MOTHER'S MAIDEN NAME Laura Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-01-7199		17. INFORMANT Address Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA 490X XXXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CIRRHOSIS OF THE LIVER DUE TO (c) UNKNOWN						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that W (this hospital) attended the deceased from 7:20 PM 3/1/1960 to 6:45 AM 3/2/1960 that W (we) last saw the deceased alive on March 2 1960 , and that death occurred at 6:45 AM , from the causes and on the date stated above.							
22a. SIGNATURE Caridad E. Gonzalez				22b. DATE SIGNED 3/2/60		22c. PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M.D.	
22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-5-60		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Frank W. Seitz Funeral Home, 814 36th St. Balto. Md.				25a. REC'D BY REGISTRAR MAR 7 '60		25b. REGISTRAR'S SIGNATURE Caridad E. Gonzalez	

CERTIFICATE OF DEATH

3006

Deceased: John Howard
Age: 31 Years
Sex: Male
Race: White
Date of Death: November 10, 1944
Place of Death: St. Louis, Missouri
Cause of Death: Heart Disease
Signature: [Signature]
Witness: [Signature]
Registrar: [Signature]

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for filing as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 *8*

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3007 CERTIFICATE OF DEATH

02976

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>3001.4</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines-Fusting Ave.</u>				d. STREET ADDRESS <u>719 E. 41st St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>E.</u> Last <u>KIPP</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>24,</u> Year <u>19 60</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 21, 1886</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>74</u> Days <u>74</u> Hours <u>74</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rtd. Operating Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Elisa J. Kipp</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>212-18-2329</u>		17. INFORMANT <u>Mr. Herman Graf, Jr.-4610 Cedar Garden Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Decomposition</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Mitral Valve Carcinoma of Atrioventricular Ring</u> DUE TO (c) <u>Brain Papillary Carcinoma of Bladder</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 ds.</u> <u>2 mos.</u> <u>1 yr.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3-1-1960</u> to <u>3-24-1960</u> that (I) (we) last saw the deceased alive on <u>3-24-1960</u> , and that death occurred at <u>457</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Wilmer K. Gallagher</u>				22b. DATE SIGNED <u>3/23/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>				22d. ADDRESS <u>6219 Frederick Rd., Balto. 28, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>3/28/60</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Swartz Cem.</u>				23d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickner & Sons - Balto.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 28 '60</u>			
25b. REGISTRAR'S SIGNATURE <u>William L. Thomas</u>							

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1902



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

3008

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02977

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b 55 TOWSON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 519 VALLEYVIEW ROAD		d. STREET ADDRESS 1519 VALLEYVIEW ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First REXFORD Middle LIONEL Last KNAUB		4. DATE OF DEATH Month MARCH Day 10 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-29-1896
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 64 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR		10b. KIND OF BUSINESS OR INDUSTRY WESTERN ELECTRIC	
11. BIRTHPLACE (State or foreign country) IOWA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CLAY L. KNAUB		14. MOTHER'S MAIDEN NAME ELLEN SPRINKLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-01-5077	
17. INFORMANT Mrs LILLIAN KNAUB - 519 VALLEYVIEW Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Hypertensive Cardio Renal DUE TO (c) Vascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 yrs		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1954 to March 10, 1960 , that (I) (we) last saw the deceased alive on March 10, 1960 , and that death occurred at 11 M, from the causes and on the date stated above.			
22a. SIGNATURE Charles F. O'Donnell M.D.		22b. DATE 3/11/60	
22c. PHYSICIAN'S NAME (Type) CHARLES F. O'DONNELL		22d. ADDRESS 7501 YORK ROAD - TOWSON - MARYLAND	
23a. BURIAL-CREMATATION, REMOVAL (Specify) 3-14-60		23b. DATE THEREOF 3-14-60	
23c. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL PARK		23d. LOCATION (City, town, or county) (State) BALTIMORE COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE HENRY W. JENKINS & SONS CO		25a. REC'D BY REGISTRAR 4905 YORK RD	
25b. REGISTRAR'S SIGNATURE Arthur S. Knaus		DATE MAR 14 '60	

05017

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

2002

1. Name of Deceased: [Illegible]

2. Sex: [Illegible]

3. Date of Birth: [Illegible]

4. Date of Death: [Illegible]

5. Place of Birth: [Illegible]

6. Place of Death: [Illegible]

7. Cause of Death: [Illegible]

8. Signature of Registrar: [Illegible]

9. Date of Registration: [Illegible]

3009

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodge Forest		c. LENGTH OF STAY IN 1b 50 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Res., 7707 Iroquois Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Laura Middle Kolb Last Kolb		4. DATE OF DEATH Month March Day 22 , Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1877
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 2 Days 22 Hours 00 Min.	11. IF UNDER 24 HRS. Months 0 Days 00 Hours 00 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Balto. Md.	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore Arringdale		14. MOTHER'S MAIDEN NAME Catherine Dorrittee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Lorraine Ray 7707 Iroquois Rd. 19, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A. S. C. U. H. D. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH One week 2 years			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 15, 1958 , to March 22, 1960 , that I last saw the deceased alive on March 13, 1960 , and that death occurred at 1:00 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John V. Conway		ADDRESS (Street, city or town, state) 914 D Street	
PHYSICIAN'S NAME (Type) John V. Conway		DATE SIGNED 3-23-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 25, 60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		22d. LOCATION (City, town, or county) (State) O'Donnell St. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda 7922 Wise Ave. 22, Md.		24a. REC'D BY REGISTRAR MAR 28 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraw			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02979

3010

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison		c. LENGTH OF STAY IN 1b X Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FOXLEIGH NURSING HOME		d. STREET ADDRESS 7802 Nashua Circle	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MILTON KOLKER First Middle Last		4. DATE OF DEATH Month 3 Day 30 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1907
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Retail	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Morris Kolker		14. MOTHER'S MAIDEN NAME Anna ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Reuben Kolker — 2809 Cheswolde Rd.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary metastases DUE TO (c) Carcinomatosis, original site unknown		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/1/60 , 19 60 , to 3/30/60 , 19 60 , that I lost saw the deceased alive on 3/27/60 , 19 60 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Daniel J. Filz		ADDRESS (Street, city or town, state) 2500 Eutaw Place; Balto. - 17, Md.	
DATE SIGNED APR 1 '60			
PHYSICIAN'S NAME (Type) DAVID L. FILTZER, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/1/60.	
22c. NAME OF CEMETERY OR CREMATORY Chizuk Amuno		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Sol Levinson & Bros. Inc. 6010 Reist. Rd. #15		24a. REC'D BY REGISTRAR DATE APR 1 '60	
24b. REGISTRAR'S SIGNATURE William S. Evans			

CERTIFICATE OF DEATH

3010

11

Deceased

Barbara

WINTERBURN ROAD

WINTER

WINTER

WINTER

WINTER

WINTERBURN ROAD

WINTERBURN ROAD

WINTERBURN ROAD

WINTERBURN ROAD

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3011 **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02380

1. NAME OF DECEASED (Type or Print) WALTER E. KRATZ			2. DATE OF DEATH Mar. 23, 1960		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>County Catonsville - 28</i> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 331 Stratford Rd.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore CATONSVILLE 52 D. STREET ADDRESS (If rural, give location) 331 Stratford Rd.		
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Oct. 11, 1891	9. AGE (In years last birthday) 68	If Under 1 Year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Spetzler's Pharmacy		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Herman Kratz			14. MOTHER'S MAIDEN NAME Florence -		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Kenneth A. Kratz - 331 Stratford Rd.	

18. CAUSE OF DEATH	I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.1		(A) Arteriosclerotic Cardio Vascular Disease 3 yrs	INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) Generalized Arteriosclerosis 5 yrs	
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)	
	IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
21a. TIME OF INJURY (Month) (Day) (Year) (Hour)		21b. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21c. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 19.58 to March 23 19.60 , that (I) (we) last saw the deceased alive on March 23 1960 , and that in (my) (our) opinion death occurred at 10:00 P. m., from the causes and on the date stated above.				
23a. SIGNATURE <i>[Signature]</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D.		23b. ADDRESS 6014 EDWARDS AVE.		23c. DATE SIGNED 3-25-60
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/26/60	24c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	
24d. LOCATION (City, town, or county) (State) Balto. Md.		25a. DATE REC'D BY MAR 28 1960		
25b. NAME OF REGISTRAR <i>[Signature]</i>		25c. FUNERAL DIRECTOR Wm. V. Tiekner Sons		

THIS IS A PERMANENT RECORD.
INFORMATION SHOULD BE CAREFULLY SUPPLIED.
WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

1

3012

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. LENGTH OF STAY IN 1b 54 ESSEX	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 300 POPLAR RD.		d. STREET ADDRESS 1 300 POPLAR RD.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle KUDZMA Last MA		4. DATE OF DEATH Month MAR Day 29 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-3-85
9. AGE (In years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY MD.	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE WILLIAM BRIDRASHWICZ		14. MOTHER'S MAIDEN NAME ANNA DOUGLAS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. SELOMIA WALDHAUSER (SAME AS ABOVE)	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Cerebral and general arteriosclerosis DUE TO (c) Interval between onset and death 3 days Several years		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cancer of the parathyroid gland (residue)	
18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-24-55 to 3-29-60 , that I last saw the deceased alive on 3-28-60 , and that death occurred at 7:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Eugene C. Baumann M.D.		ADDRESS (Street, city or town, state) 418 Eastern Ave. BALTO. MD.	
PHYSICIAN'S NAME (Type) Eugene C. Baumann		DATE SIGNED 3/30/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-2-60	
22c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connolly		ADDRESS 418 Eastern Blvd.	
24a. REC'D BY REGISTRAR MAR 31 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

106

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the registrar, the certificate should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2898

CERTIFICATE OF DEATH

02982

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1b 10 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Res., 1843 Marshall Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle V.. Last Lake				4. DATE OF DEATH Month March Day 4 Year 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 17, 1872	
9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME James Lake				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Russell Lake Address 1843 Marshall Rd. 22, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 481X Suffering DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 481X DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3-4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① Ascaridiasis ② Diabetes ③ Cholelithiasis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 7, 1960 to March 4, 1960 , that I last saw the deceased alive on March 7, 1960 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE M. Brown				ADDRESS (Street, city or town, state) 6800 Morning Star Road DATE SIGNED 3/4/60			
PHYSICIAN'S NAME (Type) Melvin B. Davis, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-7-1960		22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		22d. LOCATION (City, town, or county) (State) Strasburg, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda ADDRESS 7922 Wise Ave. 22, Md.				24a. REC'D BY REGISTRAR DATE MAR 14 '60		24b. REGISTRAR'S SIGNATURE Carlton S. Evans	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED _____</p>		<p>2. SEX _____</p>		<p>3. AGE _____</p>	
<p>4. DATE OF DEATH _____</p>		<p>5. TIME OF DEATH _____</p>		<p>6. PLACE OF DEATH _____</p>	
<p>7. CAUSE OF DEATH _____</p>		<p>8. MANNER OF DEATH _____</p>		<p>9. SIGNATURE OF DECEASED _____</p>	
<p>10. SIGNATURE OF WITNESS _____</p>		<p>11. SIGNATURE OF PHYSICIAN _____</p>		<p>12. SIGNATURE OF CLERK _____</p>	
<p>13. SIGNATURE OF JUDGE _____</p>		<p>14. SIGNATURE OF SHERIFF _____</p>		<p>15. SIGNATURE OF CORONER _____</p>	
<p>16. SIGNATURE OF DISTRICT ATTORNEY _____</p>		<p>17. SIGNATURE OF COUNTY CLERK _____</p>		<p>18. SIGNATURE OF CITY CLERK _____</p>	
<p>19. SIGNATURE OF TOWNSHIP CLERK _____</p>		<p>20. SIGNATURE OF VILLAGE CLERK _____</p>		<p>21. SIGNATURE OF POST OFFICE CLERK _____</p>	
<p>22. SIGNATURE OF SCHOOL CLERK _____</p>		<p>23. SIGNATURE OF CHURCH CLERK _____</p>		<p>24. SIGNATURE OF OTHER CLERK _____</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02983

3013

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH <u>Rosewood State Training School</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Baltimore</u>		MARYLAND		o. STATE <u>Maryland</u>		b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 4, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				d. STREET ADDRESS <u>548 Brook Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>Harry</u> Middle <u>Leroy</u> Last <u>Lampe</u>		4. DATE OF DEATH		Month <u>3</u> Day <u>4</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/26/12</u>		9. AGE (In years last birthday) <u>47</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Henry Lampe, Sr., - deceased</u>				14. MOTHER'S MAIDEN NAME <u>Anna Katherine Baer - deceased</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		INFORMANT <u>Rosewood Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pneumonia</u> <u>526X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Chronic emphysema and fibrosis</u> DUE TO (c) <u>Bronchiectasis, chronic</u>						INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u> <u>3/3/58 (?)</u> <u>2/2/58 (?)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Microcephaly with mental deficiency - birth</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/3/58</u> , 19 <u> </u> to <u>3/4/60</u> , 19 <u> </u> , that I last saw the deceased alive on <u>3/4/60</u> , 19 <u> </u> , and that death occurred at <u>7:30a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>3/4/60</u>							
ACTUAL SIGNATURE <u>Olive Reid Harris, MD</u>		PHYSICIAN'S NAME (Type) <u>Olive Reid Harris, M.D.</u> <u>Rosewood Training School.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR. 8, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns Sons</u>				ADDRESS <u>Lawson</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 9 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

3014

CERTIFICATE OF DEATH

02984

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Md. b. COUNTY Baltimore City ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V014	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in Pines, 16 Fusting Ave		d. STREET ADDRESS 135 S. Hilton St	
e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Clinton Wyatt Landon		4. DATE OF DEATH Month Day Year March 1/60 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1902
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ed. L. Landon		14. MOTHER'S MAIDEN NAME Mary Swain	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Anna E. Landon, 135 S. Hilton St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease DUE TO disease (c)		INTERVAL BETWEEN ONSET AND DEATH 2 week 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebro vascular accident			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 21 January , 19 60 to 1 Mar , 19 60 , that I lost saw the deceased alive on 29 Feb , 19 60 , and that death occurred at 54 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) James E. Rowe M.D. 3/1/60 DATE SIGNED			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) James E. Rowe M.D.		1011 Frederick Rd. #28, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/4/60	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F. D.		24a. REC'D BY REGISTRAR DATE MAR 3 '60	
ADDRESS 4101 Edmondson Ave.		24b. REGISTRAR'S SIGNATURE William S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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Abstract

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Source: *in situ* measurements.

03/11/2014

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3298 JOURNAL OF CLIMATE

1980-1981 1981-1982 1982-1983 1983-1984 1984-1985 1985-1986 1986-1987 1987-1988 1988-1989 1989-1990 1990-1991 1991-1992 1992-1993 1993-1994 1994-1995 1995-1996 1996-1997 1997-1998 1998-1999 1999-2000 2000-2001 2001-2002 2002-2003 2003-2004 2004-2005 2005-2006 2006-2007 2007-2008 2008-2009 2009-2010 2010-2011 2011-2012 2012-2013 2013-2014 2014-2015 2015-2016 2016-2017 2017-2018 2018-2019 2019-2020 2020-2021 2021-2022 2022-2023 2023-2024 2024-2025 2025-2026 2026-2027 2027-2028 2028-2029 2029-2030 2030-2031 2031-2032 2032-2033 2033-2034 2034-2035 2035-2036 2036-2037 2037-2038 2038-2039 2039-2040 2040-2041 2041-2042 2042-2043 2043-2044 2044-2045 2045-2046 2046-2047 2047-2048 2048-2049 2049-2050 2050-2051 2051-2052 2052-2053 2053-2054 2054-2055 2055-2056 2056-2057 2057-2058 2058-2059 2059-2060 2060-2061 2061-2062 2062-2063 2063-2064 2064-2065 2065-2066 2066-2067 2067-2068 2068-2069 2069-2070 2070-2071 2071-2072 2072-2073 2073-2074 2074-2075 2075-2076 2076-2077 2077-2078 2078-2079 2079-2080 2080-2081 2081-2082 2082-2083 2083-2084 2084-2085 2085-2086 2086-2087 2087-2088 2088-2089 2089-2090 2090-2091 2091-2092 2092-2093 2093-2094 2094-2095 2095-2096 2096-2097 2097-2098 2098-2099 2099-2100 2100-2101 2101-2102 2102-2103 2103-2104 2104-2105 2105-2106 2106-2107 2107-2108 2108-2109 2109-2110 2110-2111 2111-2112 2112-2113 2113-2114 2114-2115 2115-2116 2116-2117 2117-2118 2118-2119 2119-2120 2120-2121 2121-2122 2122-2123 2123-2124 2124-2125 2125-2126 2126-2127 2127-2128 2128-2129 2129-2130 2130-2131 2131-2132 2132-2133 2133-2134 2134-2135 2135-2136 2136-2137 2137-2138 2138-2139 2139-2140 2140-2141 2141-2142 2142-2143 2143-2144 2144-2145 2145-2146 2146-2147 2147-2148 2148-2149 2149-2150 2150-2151 2151-2152 2152-2153 2153-2154 2154-2155 2155-2156 2156-2157 2157-2158 2158-2159 2159-2160 2160-2161 2161-2162 2162-2163 2163-2164 2164-2165 2165-2166 2166-2167 2167-2168 2168-2169 2169-2170 2170-2171 2171-2172 2172-2173 2173-2174 2174-2175 2175-2176 2176-2177 2177-2178 2178-2179 2179-2180 2180-2181 2181-2182 2182-2183 2183-2184 2184-2185 2185-2186 2186-2187 2187-2188 2188-2189 2189-2190 2190-2191 2191-2192 2192-2193 2193-2194 2194-2195 2195-2196 2196-2197 2197-2198 2198-2199 2199-2200 2200-2201 2201-2202 2202-2203 2203-2204 2204-2205 2205-2206 2206-2207 2207-2208 2208-2209 2209-2210 2210-2211 2211-2212 2212-2213 2213-2214 2214-2215 2215-2216 2216-2217 2217-2218 2218-2219 2219-2220 2220-2221 2221-2222 2222-2223 2223-2224 2224-2225 2225-2226 2226-2227 2227-2228 2228-2229 2229-2230 2230-2231 2231-2232 2232-2233 2233-2234 2234-2235 2235-2236 2236-2237 2237-2238 2238-2239 2239-2240 2240-2241 2241-2242 2242-2243 2243-2244 2244-2245 2245-2246 2246-2247 2247-2248 2248-2249 2249-2250 2250-2251 2251-2252 2252-2253 2253-2254 2254-2255 2255-2256 2256-2257 2257-2258 2258-2259 2259-2260 2260-2261 2261-2262 2262-2263 2263-2264 2264-2265 2265-2266 2266-2267 2267-2268 2268-2269 2269-2270 2270-2271 2271-2272 2272-2273 2273-2274 2274-2275 2275-2276 2276-2277 2277-2278 2278-2279 2279-2280 2280-2281 2281-2282 2282-2283 2283-2284 2284-2285 2285-2286 2286-2287 2287-2288 2288-2289 2289-2290 2290-2291 2291-2292 2292-2293 2293-2294 2294-2295 2295-2296 2296-2297 2297-2298 2298-2299 2299-2300 2300-2301 2301-2302 2302-2303 2303-2304 2304-2305 2305-2306 2306-2307 2307-2308 2308-2309 2309-2310 2310-2311 2311-2312 2312-2313 2313-2314 2314-2315 2315-2316 2316-2317 2317-2318 2318-2319 2319-2320 2320-2321 2321-2322 2322-2323 2323-2324 2324-2325 2325-2326 2326-2327 2327-2328 2328-2329 2329-2330 2330-2331 2331-2332 2332-2333 2333-2334 2334-2335 2335-2336 2336-2337 2337-2338 2338-2339 2339-2340 2340-2341 2341-2342 2342-2343 2343-2344 2344-2345 2345-2346 2346-2347 2347-2348 2348-2349 2349-2350 2350-2351 2351-2352 2352-2353 2353-2354 2354-2355 2355-2356 2356-2357 2357-2358 2358-2359 2359-2360 2360-2361 2361-2362 2362-2363 2363-2364 2364-2365 2365-2366 2366-2367 2367-2368 2368-2369 2369-2370 2370-2371 2371-2372 2372-2373 2373-2374 2374-2375 2375-2376 2376-2377 2377-2378 2378-2379 2379-2380 2380-2381 2381-2382 2382-2383 2383-2384 2384-2385 2385-2386 2386-2387 2387-2388 2388-2389 2389

3015

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>224 Spring Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mr. Walter E. Leach</i>		4. DATE OF DEATH <i>March 17th 19 60</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 22, 1891</i>
9. AGE (In years last birthday) <i>68</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Pete's Cycle</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Benjamin Leach</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>INFORMANT</i>	
17. ADDRESS <i>Lutherville</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Fibrosis + Emphysema</i> <i>523.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>Pneumococcosis</i> (c) <i>Silicone Inhalation</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i> <i>6-7 years</i> <i>10 years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9-3-17</i> , 19 <i>56</i> , to <i>3-17</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>3-17</i> , 19 <i>60</i> , and that death occurred at <i>5:15 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Paul G. Mueller</i>		ADDRESS (Street, city or town, state) <i>6411 Belair Rd</i>	
PHYSICIAN'S NAME (Type) <i>PAUL G. MUELLER</i>		DATE SIGNED <i>Mar 16 1960</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-19-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Joseph Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Texas, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24a. REC'D BY REGISTRAR <i>5305 Harford Road #14</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>		DATE <i>MAR 21 '60</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3055

STATE OF NEW YORK

DEPARTMENT OF HEALTH

ALBANY

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CERTIFICATE OF DEATH

Reg. Dist. No.

02986

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millers</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1 day</u>		d. STREET ADDRESS <u>06X-2</u>	
3. NAME OF DECEASED (Type or print) <u>MICHAEL-D-LEISTER</u>		4. DATE OF DEATH <u>March 25</u> 19 <u>60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 8-1900</u>
9. AGE (In years loss birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trial Magistrate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Julius W Leister</u>		14. MOTHER'S MAIDEN NAME <u>Emma Brillhart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-32-2702</u>	
17. INFORMANT <u>Mrs Michael & Leister, Millers Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>3 yrs</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>47</u> , to <u>March 25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb</u> , 19 <u>60</u> , and that death occurred at <u>3 p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W H Foard</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>MANches P. Md 3/25/60</u>	
PHYSICIAN'S NAME (Type) <u>W. H Foard M.D</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-29-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward C Tipton - Hampstead Md</u>		24. REC'D BY REGISTRAR DATE <u>MAR 31 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8018 Ridgely Oak Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Howard Middle E Last Leydig		4. DATE OF DEATH Month March Day 28 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 25, 1877
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (ret'd) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Leydig		14. MOTHER'S MAIDEN NAME (unknown) McVickers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 196-14-6344	
17. INFORMANT John Leydig, 8018 Ridgely Oak Road, Towson		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) 20 yrs		INTERVAL BETWEEN ONSET AND DEATH 1 wk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-20 , 19 60 , to 3-28 , 19 60 , that I last saw the deceased alive on 3-27 , 19 60 , and that death occurred at 1:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8400 Loch Haven Blvd. 3/28/60 DATE SIGNED 3/28/60			
ACTUAL SIGNATURE Joseph F. Piramo M.D.		PHYSICIAN'S NAME (Type) JOSEPH F. PI RAMO 8400 Loch Haven Blvd. 3/28/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	22b. DATE THEREOF 3-28-60	22c. NAME OF CEMETERY OR CREMATORY Lybarger Cemetery	22d. LOCATION (City, town, or county) (State) Buffalo Mills, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24. REC'D BY REGISTRAR MAR 30 1960 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

3018

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02988

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 3V01-4			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 35 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RICHARD Middle E. Last LICHTENBERG				4. DATE OF DEATH Month March Day 4 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 16, 1898	
9. AGE (In years lost birthday) yrs. 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meter - Wireman		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles F. Lichtenberg				14. MOTHER'S MAIDEN NAME Mary Felger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 212-05-6022		17. INFORMANT Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 527.1 DUE TO CHRONIC PULMONARY EMPHYSEMA AND SHOCK Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS OR CONDITION GIVEN IN PART I (a) 1. Carcinoma of Bladder - 2. wound debridement, repair, 3. Iliac Loop Urinary Diversion & biopsy, 11ver. - 2/25/60							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				20g. (County) Baltimore			
20h. (State) Md.				20i. (Country) U. S. A.			
21. I certify that (1) (this hospital) attended the deceased from January 29, 1960 to March 4, 1960 , that (1) (we) lost saw the deceased alive on March 4, 1960 , and that death occurred at 5:35 AM from the causes and on the date stated above.							
22a. SIGNATURE Caridad E. Gonzalez M.D.				22b. DATE SIGNED 3/4/60			
22c. PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/8/60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Tickner & Sons, Inc. North and Penna. Avenues.				25a. REC'D BY REGISTRAR MAR 7 '60		25b. REGISTRAR'S SIGNATURE Cribari S. Thoma	

Baltimore, Maryland

Voluntary Administration Hospital
2711 Market Avenue
San Francisco, California

RECEIVED
JANUARY 1, 1936

For & Joseph G. Robinson, President
San Francisco

100-01-00000
San Francisco, California

RECEIVED
JANUARY 1, 1936

San Francisco, California

RECEIVED
JANUARY 1, 1936

San Francisco, California

RECEIVED
JANUARY 1, 1936

San Francisco, California

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3019

CERTIFICATE OF DEATH

02989

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point				c. LENGTH OF STAY IN 1b 37 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 617 E Street				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point (19)			
4. DATE OF DEATH Month March Day 24th Year 1960				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle ANN Last LINDEMANN				4. DATE OF DEATH Month March Day 24th Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 15, 1887	
9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR Months 2 Days 4 Hours 19 Min.		IF UNDER 24 HRS. Months 2 Days 4 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Midwife				10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles F. Hutson				14. MOTHER'S MAIDEN NAME Caroline Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-07-6798A		17. INFORMANT Benjamin Lindemann Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 260x DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) Isolated Pulmonary							INTERVAL BETWEEN ONSET AND DEATH 2 months 5 yrs. 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July , 19 50 , to March 24 , 19 60 , that I last saw the deceased alive on March 22 , 19 60 , and that death occurred at 7:29 A.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE James T. Means M.D.				503 Surrey Road 3/25/60			
PHYSICIAN'S NAME (Type) James T. Means, M.D.				Towson 4, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/28/60		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brubaker Bradley				ADDRESS Dundalk 22		24a. REC'D BY REGISTRAR DATE MAR 28 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

DATE OF DEATH 1930		PLACE OF DEATH Baltimore	
SEX Male		RACE White	
AGE 37 years		OCCUPATION Clerk	
MARITAL STATUS Single		PLACE OF BIRTH Baltimore, Maryland	
NAME OF DECEASED JAMES H. HARRIS		NAME OF FATHER JAMES H. HARRIS	
NAME OF MOTHER SARAH J. HARRIS		NAME OF SPOUSE None	
DATE OF BIRTH Dec. 12, 1892		DATE OF DEATH Dec. 12, 1930	
TIME OF DEATH 10:30 A.M.		PLACE OF DEATH Home	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF WITNESSES J. H. Harris, S. J. Harris	
SIGNATURE OF DECEASED J. H. Harris		SIGNATURE OF FATHER J. H. Harris	
SIGNATURE OF MOTHER S. J. Harris		SIGNATURE OF SPOUSE None	
SIGNATURE OF CLERK J. H. Harris		SIGNATURE OF REGISTRAR J. H. Harris	

3020

CERTIFICATE OF DEATH

02990

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Towson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenarm Road</u>				d. STREET ADDRESS <u>Glenarm Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sister Mary Lourdes Lindinger</u>				4. DATE OF DEATH Month Day Year <u>March 2 19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 3, 1872</u>		9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Lindinger</u>				14. MOTHER'S MAIDEN NAME <u>Carolina Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Sister M. Peter Fourier</u>		Address <u>Notch Cliff, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of lungs</u> <u>163x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> , to <u>March</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>March 1</u> , 19 <u>60</u> , and that death occurred at <u>9:25 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Charles F. O'Donnell M.D.</u> <u>7501 York Road Towson 4, Md.</u> <u>3/3/60</u>							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-5-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>VILLA MARIA CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>NOTCH CLIFF NR TOWSON, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles F. Geller</u>		ADDRESS <u>9015 CONKLING ST. BALTO., 24, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. PLACE OF BIRTH	
6. DATE OF DEATH		7. TIME OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF WITNESS		19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF REGISTRAR	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF WITNESS		24. SIGNATURE OF PHYSICIAN		25. SIGNATURE OF REGISTRAR	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF NEXT OF KIN		28. SIGNATURE OF WITNESS		29. SIGNATURE OF PHYSICIAN		30. SIGNATURE OF REGISTRAR	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF NEXT OF KIN		33. SIGNATURE OF WITNESS		34. SIGNATURE OF PHYSICIAN		35. SIGNATURE OF REGISTRAR	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF NEXT OF KIN		38. SIGNATURE OF WITNESS		39. SIGNATURE OF PHYSICIAN		40. SIGNATURE OF REGISTRAR	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF NEXT OF KIN		43. SIGNATURE OF WITNESS		44. SIGNATURE OF PHYSICIAN		45. SIGNATURE OF REGISTRAR	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF NEXT OF KIN		48. SIGNATURE OF WITNESS		49. SIGNATURE OF PHYSICIAN		50. SIGNATURE OF REGISTRAR	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF NEXT OF KIN		53. SIGNATURE OF WITNESS		54. SIGNATURE OF PHYSICIAN		55. SIGNATURE OF REGISTRAR	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF NEXT OF KIN		58. SIGNATURE OF WITNESS		59. SIGNATURE OF PHYSICIAN		60. SIGNATURE OF REGISTRAR	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF NEXT OF KIN		63. SIGNATURE OF WITNESS		64. SIGNATURE OF PHYSICIAN		65. SIGNATURE OF REGISTRAR	
66. SIGNATURE OF DECEASED		67. SIGNATURE OF NEXT OF KIN		68. SIGNATURE OF WITNESS		69. SIGNATURE OF PHYSICIAN		70. SIGNATURE OF REGISTRAR	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF NEXT OF KIN		73. SIGNATURE OF WITNESS		74. SIGNATURE OF PHYSICIAN		75. SIGNATURE OF REGISTRAR	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF NEXT OF KIN		78. SIGNATURE OF WITNESS		79. SIGNATURE OF PHYSICIAN		80. SIGNATURE OF REGISTRAR	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF NEXT OF KIN		83. SIGNATURE OF WITNESS		84. SIGNATURE OF PHYSICIAN		85. SIGNATURE OF REGISTRAR	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF NEXT OF KIN		88. SIGNATURE OF WITNESS		89. SIGNATURE OF PHYSICIAN		90. SIGNATURE OF REGISTRAR	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF NEXT OF KIN		93. SIGNATURE OF WITNESS		94. SIGNATURE OF PHYSICIAN		95. SIGNATURE OF REGISTRAR	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF NEXT OF KIN		98. SIGNATURE OF WITNESS		99. SIGNATURE OF PHYSICIAN		100. SIGNATURE OF REGISTRAR	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3021

CERTIFICATE OF DEATH

Reg. Dist. No.

02991
32

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 12 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE CITY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3301-4 d. STREET ADDRESS 1405 NORTH MONTFORD AVE e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle WILLIAM LINNEMANN Last WILLIAM LINNEMANN		4. DATE OF DEATH Month MARCH Day 6 Year 1960	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 22, 1889	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOKBINDER		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HERMAN B. LINNEMANN		14. MOTHER'S MAIDEN NAME THERESA SELINGSLOH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-01-5299	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) E DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CORONARY INFARCT INTERVAL BETWEEN ONSET AND DEATH 6 YEARS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB 25, 1960 , to MARCH 6, 1960 , that I last saw the deceased alive on MARCH 6, 1960 , and that death occurred at 4:35 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED			
ACTUAL SIGNATURE Wm. Newcomer PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D.		M.D. Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/9/60	
22c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTIMORE MD.		24a. REC'D BY REGISTRAR DATE MAR 8 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kross			

CERTIFICATE OF DEATH

1901

NAME		SEX		AGE		DATE OF BIRTH	
WALTER		MALE		20		JANUARY 1, 1881	
FATHER		MOTHER		PLACE OF BIRTH		DATE OF DEATH	
JAMES		MARY		BALTIMORE		JANUARY 1, 1901	
OCCUPATION		CAUSE OF DEATH		PLACE OF DEATH		DATE OF DEATH	
LABORER		HEART DISEASE		BALTIMORE		JANUARY 1, 1901	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF DEATH		DATE OF DEATH	
J. H. [Signature]		[Signature]		JANUARY 1, 1901		JANUARY 1, 1901	

3022

CERTIFICATE OF DEATH

02992

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix (Rural)		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jarrettsville Pike		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Emory Middle Lintz Last 4. DATE OF DEATH Month 3-5 Day 1960		5. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 5-1-1880 9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner-operator		10b. KIND OF BUSINESS OR INDUSTRY farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Lintz		14. MOTHER'S MAIDEN NAME Lizzie Waltz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT wife		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Intoxication DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 1 week years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1925 to March 1960 , that I last saw the deceased alive on March 1960 , and that death occurred at Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore, Md. DATE SIGNED March 1960			
ACTUAL SIGNATURE Walter M. Hammitt M.D.		PHYSICIAN'S NAME (Type) Walter M. Hammitt	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-8-60	
22c. NAME OF CEMETERY OR CREMATORY Church of Christ		22d. LOCATION (City, town, or county) (State) Jacksonville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson4, Md.		24a. REC'D BY REGISTRAR MAR 11 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, the certificate should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3022

Decedent's Name: James (Frank) Lawrence
Date of Birth: 11-11-1880
Place of Birth: Lexington, Ky.
Sex: Male
Race: White
Marital Status: Married
Cause of Death: Heart Failure
Date of Death: 11-11-1960
Place of Death: Lexington, Ky.
Signature of Physician: George L. Linn
Signature of Registrar: James Linn
Signature of Undertaker: James Linn
Signature of Witness: James Linn
Signature of Coroner: James Linn

Brooks Funeral Service, Towson, Md.
Church of Christ
Lexington, Md.

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02993

3023

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOWLEYS QUARTERS		c. LENGTH OF STAY IN 1b 50 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOWLEYS QUARTERS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BOX 479 CARROLL ISLAND ROAD				d. STREET ADDRESS BOX 479 CARROLL ISLAND ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES C LITTLE				4. DATE OF DEATH Month Day Year MARCH 7 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG 29, 1886	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO MECH		10b. KIND OF BUSINESS OR INDUSTRY DOLPHIN MEGR		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE LITTLE				14. MOTHER'S MAIDEN NAME ELLA PILFER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 216-09-4554		INFORMANT MRS IDA LITTLE		Address BOX 479 CARROLL ISLAND ROAD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic bronchitis						INTERVAL BETWEEN ONSET AND DEATH 1 day 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 26, 1956 to March 7, 1960 , that I last saw the deceased alive on Dec 17, 1959 , and that death occurred at 1 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A. H. Kolodny		ADDRESS (Street, city or town, state) 1825 Eastern Blvd Balt. 21, Md					
PHYSICIAN'S NAME (Type) A. LEWIS KOLODNY, MD		DATE SIGNED Balt. 21, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/9/1960		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEM.		22d. LOCATION (City, town, or county) (State) BALTO CITY MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Sasseln Funeral Home 7401 Belair Road #6				24a. REC'D BY REGISTRAR DATE MAR 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

3023

MASS. LAND STATE DEPT. OF HEALTH - BOSTON

1. Name of deceased: *John A. Smith*
2. Sex: *Male*
3. Age: *45*
4. Date of death: *Jan 15 1900*
5. Place of death: *Home*
6. Cause of death: *Heart Disease*
7. Signature of physician: *Dr. J. B. Brown*
8. Signature of registrar: *Wm. A. Jones*
9. Date of registration: *Jan 16 1900*
10. Place of registration: *Boston*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3024

CERTIFICATE OF DEATH

Reg. Dist. No.

02994

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKVILLE				c. LENGTH OF STAY IN 1b 12 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2500 WENTWORTH RD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle H Last Lobb				4. DATE OF DEATH Month March Day 24 Year 1960			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 25-1899	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 8 Days 24 Hours 1 Min.		11. IF UNDER 24 HRS. Months 8 Days 24 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER				10b. KIND OF BUSINESS OR INDUSTRY Dock yard		11. BIRTHPLACE (State or foreign country) ENGLAND	
12. CITIZEN OF WHAT COUNTRY? England							
13. FATHER'S NAME William				14. MOTHER'S MAIDEN NAME Lobb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. 216-30-6614			
17. INFORMANT Mrs R.O. SELL				Address - Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aneurysm of the aorta 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH ? 2.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12-28 , 19 59 , to 3-24 , 19 60 , that I last saw the deceased alive on 3-23 , 19 60 , and that death occurred at 10:45 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7122 Harford Road DATE SIGNED 3-25-60							
ACTUAL SIGNATURE Dr. Joseph Skloven				M.D. 3-25-60			
PHYSICIAN'S NAME (Type) Dr. Joseph Skloven				7122 Harford Road			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/28/1960		22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		22d. LOCATION (City, town, or county) (State) BALTO MD	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. F. Evans & Son				ADDRESS 8802 Harford Rd		24a. REC'D BY REGISTRAR MAR 29 1960	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kneiss	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
my retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 5/5B

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02995

2911

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 25yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 105 Butler Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nellie Middle Mabel Last Long		4. DATE OF DEATH Month March Day 10 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 21, 1886
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min.	11. IF UNDER 24 HRS. Months 73 Days 73 Hours 73 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James H. Doyle		14. MOTHER'S MAIDEN NAME Elizabeth Rockwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Edgar H. Long		Address 105 Butler Rd. Reisterstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) Carcinoma of the liver DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes		INTERVAL BETWEEN ONSET AND DEATH 3 mos. 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. none p. m. none		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-26-39 , 19____, to 3-10-60 , 19____, that I lost saw the deceased alive on 3-9-60 , 19____, and that death occurred on 2:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 3-11-60			
ACTUAL SIGNATURE D. D. Caples,		M.D. 6 Hanover Rd.	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 13, 1960	
22c. NAME OF CEMETERY OR CREMATORY Rockey Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Frederick County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE MAR 15 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

STATE OF CALIFORNIA
DEPARTMENT OF PUBLIC SAFETY
BUREAU OF INVESTIGATION
COMMUNICATIONS SECTION

TO : SAC, LOS ANGELES (44-1111)
FROM : SAC, SAN FRANCISCO (44-1111)
SUBJECT: [Illegible]
RE: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a multi-paragraph memorandum or report.]

44-1111-1000
[Illegible handwritten notes and stamps]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital attending physician. Pages 1 and 2 should be filed with
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, the certificate
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02996

3025

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 31yr10mth1dy	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Albert Middle Lowenstein Last Lowenstein		4. DATE OF DEATH Month Mar ch 29 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-10-1907
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 29 Days 29 Hours 29 Min.	11. IF UNDER 24 HRS. Months 29 Days 29 Hours 29 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY laborer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David L. Lowenstein		14. MOTHER'S MAIDEN NAME Minnie Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1960 , to March 29, 1960 , that I last saw the deceased alive on March 29, 1960 , and that death occurred at 2:00 p. m. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 3-29-60	
ACTUAL SIGNATURE Stella Wachslar M.D.		PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-31-60	
22c. NAME OF CEMETERY OR CREMATORY Beth Israel		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis		24a. REC'D BY REGISTRAR DATE MAR 31 '60	
ADDRESS 2100 Eutaw Place		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

8022

11

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 3026 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

02997

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore County</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Georgia</u> b. COUNTY <u>Savannah</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY IN 1b <u>35Yrs. 3Mos. 27Das.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>THE SHEPPARD AND ENOCH PRATT HOSPITAL</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward Mills MacLean</u>			4. DATE OF DEATH Month Day Year <u>March 7 19 60</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 27, 1880</u>		9. AGE (In years lost birthday) <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Textile Designer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Malcolm MacLean</u>			14. MOTHER'S MAIDEN NAME <u>Mary Mac I. Mills</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of the Myocardium</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Gen. Arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 em</u> <u>2 day</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenic Reaction, Par. Type.</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 1, 1930</u> , to <u>March 7, 1960</u> , that I last saw the deceased alive on <u>March 5, 1960</u> , and that death occurred at <u>2:55 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>W. W. Elgin</u> M. D.			DATE SIGNED <u>March 7, 1960</u>		
PHYSICIAN'S NAME (Type) <u>W. W. Elgin, M. D.</u>			The Sheppard and Enoch Pratt Hospital		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Mar. 8, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bonaventure</u>	
22d. LOCATION (City, town, or county) <u>Towson, Maryland</u>		22e. LOCATION (City, town, or county) <u>Savannah, Georgia</u>		22f. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Lickauer, Inc. Baltimore Md</u>			24a. REC'D BY REGISTRAR DATE <u>MAR 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinard</u>

CERTIFICATE OF DEATH

3028

DATE OF DEATH

PLACE OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

722 W. CON. T.

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3027 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02998

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point 19</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesaco Park 6</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethlehem Steel Dispensary</u>		d. STREET ADDRESS <u>103 Choptank Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William</u> <u>Mallon</u>		4. DATE OF DEATH Month Day Year <u>March 5 1960 19</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-11-19</u>
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pit recorded</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William A. Mallon</u>		14. MOTHER'S MAIDEN NAME <u>Margaret O'Connor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW 11</u>		16. SOCIAL SECURITY NO. <u>215-01-0382</u>	
17. INFORMANT <u>Naomi H. Mallon</u>		Address <u>103 Choptank Ave. #6</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. Davis MD</u>		DATE SIGNED <u>3-5-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/9/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 10 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3028
CERTIFICATE OF DEATH

Reg. Dist. No.

02999

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. LENGTH OF STAY IN 1b 5 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2103 Lukewood Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Stephen B. Manly		4. DATE OF DEATH Month March Day 30 Year 19 60.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-Commercial Dept. C. & P. Tel.		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stephen B. Manly		14. MOTHER'S MAIDEN NAME Mary E. Hurdle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Kathryn B. Carroll		Address 2103 Lukewood Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Cardio-vascular hypertension & failure DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Hypertensive Cardio-vascular disease DUE TO (c) 2 years		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. , 1949, to March 30 , 1960, that I last saw the deceased alive on March 30 , 1960, and that death occurred at 12:45 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Benjamin I. Siegel		ADDRESS (Street, city or town, state) DATE SIGNED 15 Greenwood Rd. Baltimore 3/31/60	
PHYSICIAN'S NAME (Type) Benjamin I. Siegel			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 4-1960	
22c. NAME OF CEMETERY OR CREMATORY London Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Howard Strong		24a. REC'D BY REGISTRAR APR 1 '60	
ADDRESS 3207 W. NORTH AVE		24b. REGISTRAR'S SIGNATURE Arthur S. Kneale	

CERTIFICATE OF DEATH

3028

Age 1-10-15

Place of Birth

Baltimore

Sex

Male

Woodward

Occupation

Woodman

1105 Jackson Drive

2103 Jackson Drive

Date of Death

August 1, 1962

Time

11:00 AM

Name

William

Sept. 4, 1962

Place of Death

St. Joseph's Hospital, Baltimore, Md.

St. Joseph's Hospital, Baltimore, Md.

Stephen B. Hardy

Harry B. Hardy

None

Mr. Kathryn B. Hardy 2103 Jackson Drive

Married

Married

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

None

Benjamin I. Hardy

April 1-1962 London, Md.

Baltimore

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3029

CERTIFICATE OF DEATH

03000

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1408 Ruxton Rd.</u>				d. STREET ADDRESS <u>1408 Ruxton Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LOUISE</u> Middle <u>FONTAINE</u> Last <u>MANN</u>			4. DATE OF DEATH Month <u>Mar.</u> Day <u>6,</u> Year <u>19 60</u>				
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1887</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Richard Morris Fontaine</u>			14. MOTHER'S MAIDEN NAME <u>Tomasia Minor</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Mr. W. Berkely Mann - Ridge Rd., Riderwood, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon (resected)</u> <u>153.8</u> DUE TO <u>with metastases to Brain + Spine</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>6 months</u> DUE TO (c) <u>6 months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March, 1958</u> , to <u>March 6, 1960</u> , that I last saw the deceased alive on <u>March 4, 1960</u> , and that death occurred at <u>7 A. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1014 St Paul St, Balt 2, Md</u> DATE SIGNED <u>3/7/60</u> ACTUAL SIGNATURE <u>J. Frank Supple</u> M.D. PHYSICIAN'S NAME (Type) <u>J. Frank Supple</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3/8/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Sicker</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr6mth16dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mamie Middle Lucricia Last Masarone		4. DATE OF DEATH Month March Day 15 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 26, 1892
9. AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Lowe		14. MOTHER'S MAIDEN NAME Jessie Tolson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 260X IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Diabetes mellitus			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 12, 19 60 to March 15, 1960 , that I last saw the deceased alive on March 15, 19 60 , and that death occurred at 3:35 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslers		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL 3-15-60	
PHYSICIAN'S NAME (Type) Stella Wachslers, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-18-60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		22d. LOCATION (City, town, or county) (State) Randallstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Foring Byers		ADDRESS 8728 Liberty Rd Randallstown	
24a. REC'D BY REGISTRAR MAR 23 60		24b. REGISTRAR'S SIGNATURE Arthur S. Thoma	

CERTIFICATE OF DEATH



NEW YORK



1 *8*

03002

2908

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u>			
c. LENGTH OF STAY IN 1b <u>25 yrs.</u>				d. STREET ADDRESS <u>1825 Clark Blvd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1825 Clark Blvd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas M^c Clooney (Clooney)</u>				4. DATE OF DEATH Month Day Year <u>March 8 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 20, 1880</u>		9. AGE (In years lost birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Tommy McClooney</u>				14. MOTHER'S MAIDEN NAME <u>Konnie Hurley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>215-09-4817</u>		17. INFORMANT Address <u>Mary E. M^c Clooney 1825 Clark Blvd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> <u>177X</u> DUE TO <u>Metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocarditis</u> (c) <u>Chronic Myocarditis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Myocarditis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs 1 yr 3 mo</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1960</u> to <u>March 8, 1960</u> , that (I) (we) last saw the deceased alive on <u>March 7, 1960</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>BB Brumbaugh</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>3/8/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>BB Brumbaugh</u>				22d. ADDRESS <u>609 Main St Elbridge 27 Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/9/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery Baltimore</u>		23d. LOCATION (City, town, or county) (State) <u>Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ambrase Tr. 1328 Sulphur Spring Rd</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 9 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

BB

CERTIFICATE OF DEATH

DOES

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3031

Items 1, 2 Film 260 4-5-60 et

CERTIFICATE OF DEATH

03003

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh c. LENGTH OF STAY IN 1b 20 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pilgrim's Rest, Vincent Rd.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh d. STREET ADDRESS (Private Residence) Pilgrim's Rest, Vincent Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WALTER GIBBS McKENNEY		4. DATE OF DEATH March 27, 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 11, 1874
9. AGE (In years last birthday) 85		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Methodist Minister		10b. KIND OF BUSINESS OR INDUSTRY Westmoreland County, Va.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas McKenney		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or date of service)		16. SOCIAL SECURITY NO. 217-12-6573	
17. INFORMANT W. Gibbs McKenney, Jr. Address 102 Estes Rd. Baltimore 12 Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arterio-sclerosis (c) Advanced age + mild diabetes		INTERVAL BETWEEN ONSET AND DEATH acute 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19, 1952 to March 12, 1960 , that I last saw the deceased alive on March 12, 1960 , and that death occurred at 5:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Karl F. Mech, M.D.		ADDRESS (Street, city or town, state) 11 E. CHASE STREET (W) BALTIMORE-2, MARYLAND	
PHYSICIAN'S NAME (Type) KARL F. MECH, M.D.		DATE SIGNED 3/28/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 30, 1960	
22c. NAME OF CEMETERY OR CREMATORY Camp Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC. Baltimore Md.		24a. REC'D BY REGISTRAR MAR 31 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed in by the funeral director, TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03004

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 22 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 812 West Franklin Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLARENCE --- MEYERS				4. DATE OF DEATH Month Day Year March 1 1960			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 20, 1885	
9. AGE (In years lost birthday) 74 yrs.		10. AGE (In years lost birthday) 74 yrs.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Planer				10b. KIND OF BUSINESS OR INDUSTRY Lumber Mill		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Tom Meyers				14. MOTHER'S MAIDEN NAME Laura MN: Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 212-03-5478		17. INFORMANT Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421.1 HYPERTROPHY AND DILATION OF THE HEART DUE TO AORTIC CALCIFIC STENOSIS AND MITRAL INSUFFICIENCY, 421.1 CHRONIC PASSIVE CONGESTION OF LUNGS, LIVER AND SPLEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 3 WEEKS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that W (this hospital) attended the deceased from Feb. 8 1960 to March 1 1960 , that W (we) last saw the deceased alive on March 1 1960 , and that death occurred at 12:05 PM from the causes and on the date stated above.							
22a. SIGNATURE Caridad E. Gonzalez M.D.				22b. DATE SIGNED 3/2/60			
22c. PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M.D.				22d. ADDRESS VAH, BALTO 18, MD. FT. HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-4-1960		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips				25a. REC'D BY REGISTRAR 17, Md.		25b. REGISTRAR'S SIGNATURE Charles S. Phillips	

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Journal of the American Academy of Child and Adolescent Psychiatry 45:10 (2006), pp 1293-1300

3033

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03005

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 22-12-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 810 East Church Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWIN Middle H. Last MORRIS		4. DATE OF DEATH Month March Day 17 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 11, 1894
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 3 Days 12 Hours 2 Min.	11. IF UNDER 24 HRS. Hours 2 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timberman		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (State or foreign country) Pittsville, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Manilus Morris		14. MOTHER'S MAIDEN NAME Cordelia Bailey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None	
17. INFORMANT Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS, MIDDLE CEREBRAL ARTERY WITH CEREBRAL INFARCT, RIGHT Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. HYPERTROPHY AND DILATATION OF HEART OLD MYOCARDIAL INFARCTION INTERVAL BETWEEN ONSET AND DEATH 3 1/2 MONTHS UNKNOWN UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HEMIPLEGIA			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (x) (this hospital) attended the deceased from December 3, 1959 to March 17, 1960 , that (x) (we) last saw the deceased alive on March 17, 1960 , and that death occurred at 6:00 AM from the causes and on the date stated above.			
22a. SIGNATURE Caridad E. Gonzalez M.D.		22b. DATE SIGNED 3/17/60	
22c. PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M.D.		22d. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-19-1960	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hill and Johnson - 705 E. Main St., Salisbury, Md.		25a. REC'D BY REGISTRAR MAR 21 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Krues			

CERTIFICATE OF DEATH

3033

Full Name: [Name] Sex: [Sex] Age: [Age]

Date of Birth: [Date] Place of Birth: [Place]

Usual Residence: [Address] Date of Death: [Date]

Time of Death: [Time] Cause of Death: [Cause]

Signature of Physician: [Signature] Signature of Informant: [Signature]

Place of Death: [Place] Date of Report: [Date]

Signature of Registrar: [Signature]

Official Record No. [Number]

Remarks: [Text]

Signature of Registrar: [Signature]

Signature of Registrar: [Signature]

Signature of Registrar: [Signature]

Signature of Registrar: [Signature]

Signature of Registrar: [Signature]

Signature of Registrar: [Signature]

Signature of Registrar: [Signature]

Signature of Registrar: [Signature]

Signature of Registrar: [Signature]

Signature of Registrar: [Signature]

Signature of Registrar: [Signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3034 Item 12 FilmG260 4-4-60 et
CERTIFICATE OF DEATH

03006

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. STREET ADDRESS 315 Ingleside Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Emil		First Middle Last Neiderhauser		4. DATE OF DEATH March 24 19 60			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> ? DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1875	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) unknown Switzerland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown Godfrey Neiderhauser				14. MOTHER'S MAIDEN NAME unknown Anna ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown		INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary thrombosis and infarction 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 5, 1960 to March 24, 1960 , that I lost s/he the deceased alive on March 24, 1960 , and that death occurred at 4:10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachler				ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 3-24-60			
PHYSICIAN'S NAME (Type) Stella Wachler, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/28/60		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				ADDRESS 5305 Harford Road #14		24a. REC'D BY REGISTRAR DATE MAR 30 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

Page 4
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH



3035

CERTIFICATE OF DEATH

03007

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3215 Mayfair Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nathan</u> First <u>Norwitz</u> Middle <u>Norwitz</u> Last		4. DATE OF DEATH Month <u>3</u> - Day <u>23</u> - Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Morris</u>		14. MOTHER'S MAIDEN NAME <u>Rachael</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Bessie Norwitz - Same</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> <u>420.1</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Recent myocardial infarction</u> DUE TO <u>chronic arteriosclerosis</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>13 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-25</u> , 19 <u>57</u> , to <u>3/23/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/17/60</u> , 19 <u>60</u> , and that death occurred at <u>6:30</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Milton B. Kirsh, M.D.</u>		ADDRESS (Street, city or town, state) <u>2325 Eutaw Pl Baltimore Md</u> DATE SIGNED <u>3/23/60</u>	
PHYSICIAN'S NAME (Type) <u>Milton B. Kirsh, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>3-24-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>no 2100 Eutaw Pl</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 28 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate has been signed by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon paper: pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>		<p>7. PLACE OF DEATH</p>	
<p>8. OCCUPATION</p>		<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>		<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>		<p>13. SIGNATURE OF WITNESSES</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF DECEASED</p>		<p>17. SIGNATURE OF DECEASED</p>		<p>18. SIGNATURE OF DECEASED</p>		<p>19. SIGNATURE OF DECEASED</p>		<p>20. SIGNATURE OF DECEASED</p>		<p>21. SIGNATURE OF DECEASED</p>	
<p>22. SIGNATURE OF DECEASED</p>		<p>23. SIGNATURE OF DECEASED</p>		<p>24. SIGNATURE OF DECEASED</p>		<p>25. SIGNATURE OF DECEASED</p>		<p>26. SIGNATURE OF DECEASED</p>		<p>27. SIGNATURE OF DECEASED</p>		<p>28. SIGNATURE OF DECEASED</p>	
<p>29. SIGNATURE OF DECEASED</p>		<p>30. SIGNATURE OF DECEASED</p>		<p>31. SIGNATURE OF DECEASED</p>		<p>32. SIGNATURE OF DECEASED</p>		<p>33. SIGNATURE OF DECEASED</p>		<p>34. SIGNATURE OF DECEASED</p>		<p>35. SIGNATURE OF DECEASED</p>	
<p>36. SIGNATURE OF DECEASED</p>		<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF DECEASED</p>		<p>39. SIGNATURE OF DECEASED</p>		<p>40. SIGNATURE OF DECEASED</p>		<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF DECEASED</p>	
<p>43. SIGNATURE OF DECEASED</p>		<p>44. SIGNATURE OF DECEASED</p>		<p>45. SIGNATURE OF DECEASED</p>		<p>46. SIGNATURE OF DECEASED</p>		<p>47. SIGNATURE OF DECEASED</p>		<p>48. SIGNATURE OF DECEASED</p>		<p>49. SIGNATURE OF DECEASED</p>	
<p>50. SIGNATURE OF DECEASED</p>		<p>51. SIGNATURE OF DECEASED</p>		<p>52. SIGNATURE OF DECEASED</p>		<p>53. SIGNATURE OF DECEASED</p>		<p>54. SIGNATURE OF DECEASED</p>		<p>55. SIGNATURE OF DECEASED</p>		<p>56. SIGNATURE OF DECEASED</p>	
<p>57. SIGNATURE OF DECEASED</p>		<p>58. SIGNATURE OF DECEASED</p>		<p>59. SIGNATURE OF DECEASED</p>		<p>60. SIGNATURE OF DECEASED</p>		<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF DECEASED</p>		<p>63. SIGNATURE OF DECEASED</p>	
<p>64. SIGNATURE OF DECEASED</p>		<p>65. SIGNATURE OF DECEASED</p>		<p>66. SIGNATURE OF DECEASED</p>		<p>67. SIGNATURE OF DECEASED</p>		<p>68. SIGNATURE OF DECEASED</p>		<p>69. SIGNATURE OF DECEASED</p>		<p>70. SIGNATURE OF DECEASED</p>	
<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF DECEASED</p>		<p>73. SIGNATURE OF DECEASED</p>		<p>74. SIGNATURE OF DECEASED</p>		<p>75. SIGNATURE OF DECEASED</p>		<p>76. SIGNATURE OF DECEASED</p>		<p>77. SIGNATURE OF DECEASED</p>	
<p>78. SIGNATURE OF DECEASED</p>		<p>79. SIGNATURE OF DECEASED</p>		<p>80. SIGNATURE OF DECEASED</p>		<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF DECEASED</p>		<p>83. SIGNATURE OF DECEASED</p>		<p>84. SIGNATURE OF DECEASED</p>	
<p>85. SIGNATURE OF DECEASED</p>		<p>86. SIGNATURE OF DECEASED</p>		<p>87. SIGNATURE OF DECEASED</p>		<p>88. SIGNATURE OF DECEASED</p>		<p>89. SIGNATURE OF DECEASED</p>		<p>90. SIGNATURE OF DECEASED</p>		<p>91. SIGNATURE OF DECEASED</p>	
<p>92. SIGNATURE OF DECEASED</p>		<p>93. SIGNATURE OF DECEASED</p>		<p>94. SIGNATURE OF DECEASED</p>		<p>95. SIGNATURE OF DECEASED</p>		<p>96. SIGNATURE OF DECEASED</p>		<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF DECEASED</p>	
<p>99. SIGNATURE OF DECEASED</p>		<p>100. SIGNATURE OF DECEASED</p>		<p>101. SIGNATURE OF DECEASED</p>		<p>102. SIGNATURE OF DECEASED</p>		<p>103. SIGNATURE OF DECEASED</p>		<p>104. SIGNATURE OF DECEASED</p>		<p>105. SIGNATURE OF DECEASED</p>	

2912

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 50 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Piney Grove Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle S. Last Osborn		4. DATE OF DEATH Month March Day 15 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1877
9. AGE (In years lost birthday) 82		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Baltimore City	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Noah Garland		14. MOTHER'S MAIDEN NAME Rachel Coalhour	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-40-8375	
17. INFORMANT William D. Osborn		Address Reisterstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C-V Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes INTERVAL BETWEEN ONSET AND DEATH 23 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 1-12-37 , 19____, to 3-15-60 , 19____, that I last saw the deceased alive on 3-14-60 , 19____, and that death occurred at 8:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. Reisterstown, Md. DATE SIGNED 3-17-60			
ACTUAL SIGNATURE D. D. Caples		M.D. 6 Hanover Rd. Reisterstown, Md.	
PHYSICIAN'S NAME (Type) D. D. Caples, M.D.		DATE 3-17-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/60	
22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove		22d. LOCATION (City, town, or county) (State) Boring Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F.Eline & Sons		24a. REC'D BY REGISTRAR MAR 21 60	
ADDRESS Reisterstown, Md.		24b. REGISTRAR'S SIGNATURE James E. Turner	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3408

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and cause of death. The text is faint and mostly illegible.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3036
CERTIFICATE OF DEATH

03009

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Washington		c. LENGTH OF STAY IN 1b X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2322 Smith Ave.		d. STREET ADDRESS 2322 Smith Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIS Middle EDWIN Last OVERTON		4. DATE OF DEATH Month Mar. Day 9, Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1903
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Industrial Painter		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Willis E. Overton		14. MOTHER'S MAIDEN NAME Samantha P. (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Erma M. Overton - 2322 Smith Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Several years 6 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 Mar. 1960 to 9 Mar. 1960 , that I last saw the deceased alive on 19 , and that death occurred at 10:15 P.M. from the causes and on the date stated above. Deceased followed by Dr. Martin Shaeffer ACTUAL SIGNATURE Paul H Royse M.D. Reisterstown Md. 808 Reisterstown Rd. PHYSICIAN'S NAME (Type) PAUL H. Royse, MD Pikesville 8, Md.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/14/60	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mr. J. T. Lickner & Sons - Balt		24a. REC'D BY REGISTRAR DATE MAR 14 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

CERTIFICATE OF DEATH

3083

<p>1. NAME OF DECEASED [Faint, illegible text]</p>		<p>2. SEX [Faint, illegible text]</p>		<p>3. AGE [Faint, illegible text]</p>	
<p>4. DATE OF DEATH [Faint, illegible text]</p>		<p>5. TIME OF DEATH [Faint, illegible text]</p>		<p>6. PLACE OF DEATH [Faint, illegible text]</p>	
<p>7. CAUSE OF DEATH [Faint, illegible text]</p>		<p>8. MANNER OF DEATH [Faint, illegible text]</p>		<p>9. SIGNATURE OF DECEASED [Faint, illegible text]</p>	
<p>10. SIGNATURE OF WITNESS [Faint, illegible text]</p>		<p>11. SIGNATURE OF PHYSICIAN [Faint, illegible text]</p>		<p>12. SIGNATURE OF CLERK [Faint, illegible text]</p>	
<p>13. SIGNATURE OF JUDGE [Faint, illegible text]</p>		<p>14. SIGNATURE OF SHERIFF [Faint, illegible text]</p>		<p>15. SIGNATURE OF CORONER [Faint, illegible text]</p>	

3037

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>1 week</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Court Home</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SILAS - M - PEREGOY</u>		4. DATE OF DEATH <u>Mar 4</u> 19 <u>60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 10 1873</u> 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hammer</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Michael A Peregoy</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Spindler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs Mabel Mays - Parkton Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Decompensative Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/26</u> , 19 <u>60</u> , to <u>3/4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/4</u> , 19 <u>60</u> , and that death occurred at <u>4:25 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6805 York Rd. Baltimore 12 Md</u> DATE SIGNED <u>3/4/60</u>			
ACTUAL SIGNATURE <u>Laurence C. Post</u>		M.D. <u>Baltimore 12 Md</u>	
PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-8-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mr Canuel</u>	22d. LOCATION (City, town, or county) (State) <u>Balto co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Chipton - Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 8 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the registrar, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA CERTIFICATE OF DEATH

1911

STATE OF CALIFORNIA

DEPARTMENT OF PUBLIC HEALTH

CERTIFICATE OF DEATH

1911

1911

1911

1911

1911

1911

1911

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1911

Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒

Yes

Month	Day	Year
March	28	1960

R IF UNDER 24 HR

	Hour	Min
1	1	1
2	1	2
3	1	3
4	1	4
5	1	5
6	1	6
7	1	7
8	1	8
9	1	9
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131	1	131
132	1	132
133	1	133
134		

12. CITIZEN OF WHAT COUNTRY?

FOIA b 7 - C

OTHER'S MAIDEN NAME
TDA CLARY

Hospital Records, Mt. Wilson State Hospital

INTERVAL BETWEEN ONSET AND DEATH

Coronary Thrombosis
Pulmonary Tuberculosis

23/60
and
3/28/60

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED?
YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY	Month,	Day,	Year
Hour	a. m.		
	p. m.		19

20d. INJURY OCCURRED

While at work	Not while at work
<input type="checkbox"/>	<input type="checkbox"/>

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I **certify** that I attended the deceased from 3/26/1960, 1960, to 3/28/1960, that I last saw the deceased alive on 3/27/1960, and that death occurred at 7:30 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED _____

ACTUAL SIGNATURE W. M. M. M. M.

M.D. Mt. Wilson, Maryland

PHYSICIAN'S
NAME (Type)

Wm. Newcomer M.D.

Superintendent

22a. BURIAL, CREMATION
REMOVAL (Specify)
BURIAL

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Wm. Cook, Inc., 1217 St. Paul Street

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE **MAR 30 '60**

Clothing & House

CERTIFICATE OF DEATH

1935



Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John F. Smith		Male		45		Jan 15, 1890		New York City, N.Y.	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death	
Myocardial Infarction		Coronary Atherosclerosis		Hypertension		Natural		Home	
Date of Death		Time of Death		Place of Death		Physician's Signature		Physician's Title	
Jan 20, 1935		10:30 AM		Home		J. H. Jones, M.D.		Physician	
Burial or Disposition		Place of Burial		Date of Burial		Burial Officer's Signature		Burial Officer's Title	
Buried		St. John's Church		Jan 22, 1935		W. H. Brown		Burial Officer	
Remarks		Autopsy		Postmortem		Toxicology		Other	
None		No		No		No		No	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12, Film 6259, 3/18/60, lb

CERTIFICATE OF DEATH

03012

Reg. Dist. No.

3039

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) & Valley Foxleigh Nursing Home-Reisterstown Rd		d. STREET ADDRESS 2334 Ocala Ave.	
3. NAME OF DECEASED (Type or print) First JOSEPHINE Middle PITTI Last PITTI		4. DATE OF DEATH Month Mar. Day 9 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March, 19 1900
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Salvatore Liberto	
14. MOTHER'S MAIDEN NAME Rosaria Barranco		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mr. Samuel Lucido - 4826 Coleherne Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thromboses - recurrent 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 332x DUE TO (c) 332x			INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/18 , 19 60 , to 3/19 , 19 60 , that I last saw the deceased alive on 3/18 , 19 60 , and that death occurred at 12 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M. B. King		ADDRESS (Street, city or town, state) 2334 Ocala Ave.	
PHYSICIAN'S NAME (Type) M. B. King		DATE SIGNED 3/18/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/12/60	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickerson & Sons - Balto 17		24a. REC'D BY REGISTRAR DATE MAR 14 '60	
24b. REGISTRAR'S SIGNATURE Arthur E. Frawley			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Then please remove carbon paper pages 1 and 2 should be filed with the registrar.

10

2

100

2010 CERTIFICATE OF DEATH

3040

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 2 YEARS-8 MO.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		d. STREET ADDRESS 3351 KESWICK ROAD	
3. NAME OF DECEASED (Type or print) First Middle Last BARBARA ELLEN PORTS		4. DATE OF DEATH Month Day Year MARCH 13 1960	
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/22/1863
9. AGE (In years last birthday) 96		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME MORDICA PRICE		14. MOTHER'S MAIDEN NAME RACHEL ARMA COST	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Frank L. Smith Jr. - Cockeysville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardiac 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-10 , 19 57 , to 3-13 , 19 60 , that (I) (we) last saw the deceased alive on 3-13 , 19 60 , and that death occurred at 5:20 P. M., from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees		22b. DATE SIGNED 3/13/60	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE MD	
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		23b. DATE THEREOF 3-16-60	
23c. NAME OF CEMETERY OR CREMATORY Grace M.E. Cemetery		23d. LOCATION (City, town, or county) (State) Hampstead, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR DATE MAR 15 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1001

STATE OF NEW YORK
DEPARTMENT OF HEALTH

3040

IN SENATE
January 1, 1914
REPORT
OF THE
COMMISSIONER OF HEALTH
FOR THE YEAR
1913
ALBANY
1914

ALBANY
1914

3041

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Idylwild.</u>				c. LENGTH OF STAY IN 1b <u>14 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6515 Sherwood Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jessie V. Rampley</u>				4. DATE OF DEATH Month Day Year <u>March 17 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 12, 1885</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>White Hall, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Pearce</u>				14. MOTHER'S MAIDEN NAME <u>Mary Frances Lytle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Mrs. Lida Street, 6515 Sherwood Rd. Baltimore, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSION CARDIO-VASCULAR RENAL DISEASE 17 YRS.</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL HEMORRHAGE WITH HEMIPLEGIA (R) 10 YRS.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>MARCH 31, 1946</u> to <u>MARCH 17, 1960</u> , that I last saw the deceased alive on <u>MARCH 16, 1960</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lloyd E. Saylor</u>				ADDRESS (Street, city or town, state) <u>3902 GREENMOUNT AVE.</u>			
PHYSICIAN'S NAME (Type) <u>LLOYD E. SAYLOR</u>				DATE SIGNED <u>BALTIMORE-18 MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/20/60</u>		<u>Vernon Cemetery</u>		<u>White Hall Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartington, New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. The text appears to be a form with various fields and headings.]



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3042

CERTIFICATE OF DEATH

Reg. Dist. No.

03015

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>		c. LENGTH OF STAY IN 1b <u>10 mo 14 da</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Foxleigh Convalescent Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY Louise REDWOOD</u>		4. DATE OF DEATH Month Day Year <u>MARCH 5 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEP 23 1889</u>
9. AGE (In years last birthday) <u>70 1/2</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edwin R. Meade</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Sleight</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>John Redwood Jr.</u>		Address <u>1900 Ruxton Rd Ruxton, MO</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ATHEROSCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>AUGUST</u> , 19 <u>57</u> , to <u>MARCH</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>MARCH 15</u> , 19 <u>60</u> , and that death occurred at <u>10:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Francis T. Daly</u>		DATE SIGNED <u>3/5/60</u>	
PHYSICIAN'S NAME (Type) <u>FRANCIS T. DALY</u>		ADDRESS (Street, city or town, state) <u>1725 REISTERSTOWN RD. BALTO. MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-8-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO MD.</u>
23. BURIAL DIRECTOR'S SIGNATURE <u>H.W. JENKINS & SONS Co.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 7 '60</u>	
ADDRESS <u>4905 YORK RD, BALTO.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

VS A15 (4)
15M 9/58

100

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

3062

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

47

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 6 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2899 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03016

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 10 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3402 Cornwall Road			d. STREET ADDRESS 1 3402 Cornwall Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) SEBASTIAN J. REMLEIN SR.			4. DATE OF DEATH Month March Day 9 Year 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1887		9. AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME Amelia Whitzel		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-03-6876	17. INFORMANT Address Gordon L. Remlein 3640 Lyndale Avenue		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V-DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/8/60.	
EXAMINER'S NAME (Type) M. B. DAVIS M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 12, 1960		22c. NAME OF CEMETERY OR CREMATORY Parkwood	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland		24a. REC'D BY REGISTRAR DATE MAR 11 '60			
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc. 1901 Eastern Ave.		24b. REGISTRAR'S SIGNATURE Arthur E. Kline			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
2828 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Name]		SEX [Male/Female]		AGE [Age]	
PLACE OF BIRTH [Place]		DATE OF BIRTH [Date]		OCCUPATION [Occupation]	
MARITAL STATUS [Single/Married/Widowed]		DATE OF MARRIAGE [Date]		PLACE OF MARRIAGE [Place]	
PRESENT RESIDENCE [Address]		DATE OF DEATH [Date]		TIME OF DEATH [Time]	
CAUSE OF DEATH [Cause]		MANNER OF DEATH [Manner]		PLACE OF DEATH [Place]	
SIGNATURE OF EXAMINER [Signature]		DATE [Date]		TIME [Time]	
NAME OF HOSPITAL [Hospital Name]		ADDRESS OF HOSPITAL [Address]		CITY [City]	
STATE [State]		COUNTY [County]		ZIP CODE [ZIP Code]	

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03017

3043

1. NAME OF DECEASED (Type or Print) <u>WILLIAM J. RENSHAW</u>		2. DATE OF DEATH <u>3/14/60</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Baltimore Co. Md</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>MARYLAND</u>	
B. FULL NAME OF (If not in hospital or institution, give street address or hospital or institution) <u>6704 German Hill Rd</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>X Baltimore 24 md</u>	
X. Length of stay in Baltimore Yrs. <u>0</u> Mos. <u>0</u> Days <u>0</u>		D. STREET ADDRESS (If rural, give location) <u>16704 German Hill Rd</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1893-Dec 30</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxi Driver</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Relief Case G. L. Morris</u>	9. AGE (In years last birthday) <u>66</u> If Under 1 Year: Months <u>0</u> Days <u>0</u> If Under 24 Hours: Hours <u>0</u> Min. <u>0</u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wm. J. Renshaw</u>		14. MOTHER'S MAIDEN NAME <u>Susan E. Andrews Richmond</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>226-07-4088</u>	
17. INFORMANT <u>Silas T. Renshaw</u>		ADDRESS <u>4003 Lawson St</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthemia, etc. It means the disease, injury or complication which caused death.) <u>Hypertensive cardio vascular disease - cardiac sclerosis</u> DUE TO <u>chronic alcoholism</u> <u>chronic arthritis</u> 4443X ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST. <u>chronic arthritis</u>			INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION	
21D. TIME (Month) (Day) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from <u>1954</u> to <u>1960</u> , that (I) (we) last saw the deceased alive on <u>March 1960</u> , and that death occurred at <u>1960</u> m., from the causes and on the date stated above.		23A. SIGNATURE <u>Harry J. Siebert</u>	
23B. ADDRESS <u>6706 Eastern Ave</u>		23C. DATE SIGNED <u>3/15/60</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>3/24/60</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Green Haven Mem. Pk.</u>	24D. LOCATION (City, town, or county) (State) <u>Green Belts, Md</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>MAR 28 1960</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	
25. FUNERAL DIRECTOR <u>George J. Gorce</u>		ADDRESS <u>4001 Ritchie</u>	

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.
Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly.
HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

ML CERTIFICATION

PLANT INDUSTRY REPORT

1. NAME OF PLANT: _____

2. LOCATION: _____

3. DATE OF VISIT: _____

4. NAME OF VISITOR: _____

5. NAME OF HOST: _____

6. PURPOSE OF VISIT: _____

7. SUMMARY OF VISIT: _____

8. DETAILED DESCRIPTION OF PLANT: _____

9. SPECIES IDENTIFICATION: _____

10. CULTIVATION METHODS: _____

11. HARVESTING METHODS: _____

12. USES OF PLANT: _____

13. COMMENTS: _____

PLANT INDUSTRY REPORT

1. NAME OF PLANT: _____

2. LOCATION: _____

3. DATE OF VISIT: _____

4. NAME OF VISITOR: _____

5. NAME OF HOST: _____

6. PURPOSE OF VISIT: _____

7. SUMMARY OF VISIT: _____

8. DETAILED DESCRIPTION OF PLANT: _____

9. SPECIES IDENTIFICATION: _____

10. CULTIVATION METHODS: _____

11. HARVESTING METHODS: _____

12. USES OF PLANT: _____

13. COMMENTS: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3044

CERTIFICATE OF DEATH

Reg. Dist. No.

03018

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 13yr4mth13dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Agnes Last Reynolds		4. DATE OF DEATH Month March Day 17 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1881
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Meiers		14. MOTHER'S MAIDEN NAME Mary Sheltner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Senile brain disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 24, 1960 to March 17, 1960 , that I last saw the deceased alive on March 17, 1960 , and that death occurred at 5:30 p. m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 3-18-60	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/21/60	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichener & Sons - Balto.		24a. REC'D BY REGISTRAR DATE MAR 21 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

CERTIFICATE OF DEATH

3064

10

WILLIAM J. ADAMS
2080100302

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3045

CERTIFICATE OF DEATH

03019

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2221 Wilker Avenue</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Parkville</u> d. STREET ADDRESS <u>1 2221 Wilker Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jack</u> Middle <u>Roberts</u> Last <u>Roberts</u>		4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>19 60</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-9-1920</u>
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna.</u>	11. BIRTHPLACE (State or foreign country) <u>USA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Roberts</u>	
14. MOTHER'S MAIDEN NAME <u>Mamie French</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>	
16. SOCIAL SECURITY NO. <u>211-10-5223</u>		17. INFORMANT <u>Elfriede Roberts</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic melanoma</u> <u>190.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Primary melanoma of back</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs.</u> <u>2 1/2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March, 1960</u> to <u>March, 1960</u> that I last saw the deceased alive on <u>March 29, 1960</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Elliott Harris</u> M.D.		ADDRESS (Street, city or town, state) <u>2100 Harford Rd., Balto., Md. 3/25/60</u>	
PHYSICIAN'S NAME (Type) <u>S. Elliott Harris</u>		DATE SIGNED <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/30/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Middlelinville Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

CERTIFICATE OF DEATH

3042

Residence

1000

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3046

CERTIFICATE OF DEATH

Reg. Dist. No.

03020
32

1. PLACE OF DEATH o. COUNTY Baltimore County M		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 2 MONTHS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 29 3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 700 DEVONSHIRE ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MINNIE MARIE ROPKA		4. DATE OF DEATH Month Day Year 3 - 8 - 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-18-1880	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME WILLIAM HARRIS		14. MOTHER'S MAIDEN NAME PATTIE ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577-18-5485		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS FAR ADVANCED 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) AGRANULOCYTOSIS GENERALLY AND UNSPECIFIED					INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 - 7 - 1960 , to 3 - 8 - 1960 , that I last saw the deceased alive on 3 - 8 - 1960 , and that death occurred at 2:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED 3 - 8 - 60					
ACTUAL SIGNATURE W. W. Newcomer, M.D.		M.D. Spperintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH 11, 1960		22c. NAME OF CEMETERY OR CREMATORY WASHINGTON NATIONAL	
22d. LOCATION (City, town, or county) SUITLAND		(State) MD			
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.		ADDRESS Pleasant Ave River Dale, Md		24a. REC'D BY REGISTRAR DATE MAR 11 '60	
				24b. REGISTRAR'S SIGNATURE C. Paul S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MEDICAL CERTIFICATION

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH

3041

022

Prisoner

For Honor

Government Administration Hospital

WHITE

Male

White

June 11, 1901

Baltimore

Harmonie Street

North Baltimore

U. S. A.

Harry B. Smith

John Smith

Yes

Yes

212-0-2017

Baltimore, Md.
U. S. Army, Division
of Medical Service

INVESTIGATION OF DEATH
BY THE COMMISSIONER OF HEALTH

1. Signature of Physician

February 15, 1901

March 5

20/100

Wm. B. Smith, M.D., Baltimore, Md.

Wm. B. Smith, M.D., Baltimore, Md.

Chief of Bureau, Baltimore, Md.

20/100

20/100

20/100

3048

CERTIFICATE OF DEATH

Reg. Dist. No.

03022

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY aa	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4402 Annapolis Rd 02X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 629 Sussex Rd		d. STREET ADDRESS Balto 25 MD	
3. NAME OF DECEASED (Type or print) First MARY Middle SALEY Last SALEY		4. DATE OF DEATH Month 3 Day 17 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-27-90
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John GERD		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. INFORMANT	
17. ADDRESS Family - 629 Sussex Rd.			
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) Chronic Thrombotic Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1, 1960 , to March 17, 1960 , that I last saw the deceased alive on March 17, 1960 , and that death occurred at 7:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6895 York Rd 3/18/60			
ACTUAL SIGNATURE Laurence C. Post M.D.		DATE SIGNED 3/18/60	
PHYSICIAN'S NAME (Type) LAURENCE C. Post		Baltimore 12 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-21-60	22c. NAME OF CEMETERY OR CREMATORY Glen Burnie	22d. LOCATION (City, town, or county) (State) Glen Burnie, MD.
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes		24a. REC'D BY REGISTRAR DATE MAR 21 '60	
ADDRESS 130 E. Fort Ave		24b. REGISTRAR'S SIGNATURE Arthur S. Kinn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1902

10-1-10

WILLIAM J. HARRIS

WILLIAM J. HARRIS

WILLIAM J. HARRIS

WILLIAM J. HARRIS

1
 3049
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

03023

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Balto.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Anneslie</i>		c. LENGTH OF STAY IN 1b <i>4 1/2 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Anneslie</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>501 Regester ave</i>				1 d. STREET ADDRESS <i>501 Regester ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>JOHN</i> Middle <i>WESLEY</i> Last <i>SAVAGE</i>				4. DATE OF DEATH Month <i>Mar</i> Day <i>11</i> Year <i>1960</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 15, 1898</i>		9. AGE (In years lost birthday) <i>61</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Store Keeper State Hospital</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George T. Savage</i>				14. MOTHER'S MAIDEN NAME <i>Lucille Murphy</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>WINI 219-05-9644</i>		17. INFORMANT <i>Mr Ruth B. Savage</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <i>Hypertensive Cardiovascular Disease</i> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>1 DAY</i> <i>KNOWN FOR AT LEAST 5 YRS.</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Emphysema</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>11/22</i> 19 <i>55</i> to <i>3/11</i> 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>3/11</i> 19 <i>60</i> , and that death occurred at <i>8:30</i> AM, from the causes and on the date stated above.							
22a. SIGNATURE <i>Robert W. Gebhardt</i>				22b. ADDRESS <i>1211 NORTHERN PKWY BALTO. 12, MD.</i>		22c. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>ROBERT W. GEBHARDT</i>				22d. ADDRESS <i>1211 NORTHERN PKWY BALTO. 12, MD.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Mar. 14, 1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>London Park Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins & Sons, Co. 4905 York Road,</i>				25a. REC'D BY REGISTRAR <i>MAR 14 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

CERTIFICATE OF DEATH

1914

State of New York, County of ...

On the ... day of ... 1914

I, the undersigned, a duly qualified ...

do hereby certify that ...

... died on the ... day of ... 1914

at the age of ... years

... of the County of ...

State of New York

Signature of ...

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3050

03024

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 700 Walker Ave.				d. STREET ADDRESS 700 Walker Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HELEN Middle ELIZABETH Last SCANLAND				4. DATE OF DEATH Month Mar. Day 16, Year 19 60			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 11, 1902		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter P. Mullineaux				14. MOTHER'S MAIDEN NAME Sarah --			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-12-0524		17. INFORMANT Mr. Alonzo H. Scanland - 700 Walker Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic changes in heart - 10 yrs lying cause lost. (c) chronic						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1957 to 3/16 19 60 that (I) (was) last saw the deceased alive on 3/9 19 60 and that death occurred at 9:30 AM, from the causes and on the date stated above.							
22a. SIGNATURE Donald L. Richter				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Donald L. Richter				22d. ADDRESS 3128 Harford Rd			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/19/60		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION (City, town, or county) (State) Balto., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons - Balto 17				25a. REC'D BY REGISTRAR MAR 21 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

5020

12

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59

03925

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Dundalk</u>			
	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8125 Gray Haven Road</u>				d. STREET ADDRESS <u>8125 Gray Haven Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
	3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>K.</u> Last <u>Schavittic</u>				4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1960</u>			
	5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 27, 1904</u>		9. AGE (In years last birthday) <u>56</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
	13. FATHER'S NAME <u>George Fifer</u>				14. MOTHER'S MAIDEN NAME <u>Anna E. Marion</u>			
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Joseph E. Carey</u> Address <u>408 N. Linwood Ave. Balto.</u>			
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>-----</u> DUE TO (c) <u>-----</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 month</u>
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>14 March 1960</u> , to <u>18 March 1960</u> , that (I) (we) last saw the deceased alive on <u>18 March 1960</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.								
22a. SIGNATURE <u>Morris Rainess, M.D.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-19-60</u>		
22c. PHYSICIAN'S NAME (Type) <u>MORRIS RAINESS, M.D.</u>				22d. ADDRESS <u>1105 OLD EASTERN AVE. ESSEX-21, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/22/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u> ADDRESS <u>3000 E. Balto. St. Balto. Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 24 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>		

STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

1990



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Film G259 3-21-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

03026

1. PLACE OF DEATH a. COUNTY 3051 Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 2yr7mth6dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park, Maryland		d. STREET ADDRESS Box 409 - Route #2 Norwich and Dundee Rds.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Julia F. (Alias Weber) SCHELLENBERGE		4. DATE OF DEATH Month March Day 16 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 31 1880
9. AGE (In years last birthday) XX 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) XXXX BALTIMORE MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George SCHMIDT		14. MOTHER'S MAIDEN NAME Julia WHIPPLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 213-03-9870	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 15 , 19 60 , to March 16 , 19 60 , that I last saw the deceased alive on March 16 , 19 60 , and that death occurred at 1:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 3-16-60			
ACTUAL SIGNATURE Anthony S. Garafano M.D.		PHYSICIAN'S NAME (Type) Anthony S. Garafano, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAR. 19, 1960	
22c. NAME OF CEMETERY OR CREMATORY MOUNT OLIVET CEM.		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC.		ADDRESS BALTIMORE MARYLAND DATE MAR 21 '60	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3052

Items 8, 14 Film G259 3-28-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

03027

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cross Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Schott Last (S-ott)		4. DATE OF DEATH Month March Day 18 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-4-1884 1883
9. AGE (In years lost birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Schott		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-40-9253	
17. INFORMANT Charles Schott		Address Cross Road Perry Hall Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension and Arteriosclerosis DUE TO Yrs (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov , 19 59 , to death , 19 60 , that I last saw the deceased alive on Jan 28 , 19 60 , and that death occurred at 530 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9660 Belair Rd Balto 6 Md DATE SIGNED 3/21/60			
ACTUAL SIGNATURE George D. Edwards		M.D. 9660 Belair Rd Balto 6 Md	
PHYSICIAN'S NAME (Type) GEORGE D. EDWARDS, M.D.		9660 Belair Rd, Baltimore, 6, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-22-60	
22c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lillian Saml Home 7401 Belair Rd.		24a. REC'D BY REGISTRAR DATE MAR 23 '60	
24b. REGISTRAR'S SIGNATURE Robert S. Evans			

0032



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
extend the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2961 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03028

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	c. LENGTH OF STAY IN 1b 40 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Res., 7955 St. Monica Drive		d. STREET ADDRESS 7955 St. Monica Drive	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Anna Middle Matilda Last Schrivier		4. DATE OF DEATH Month March Day 6 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 7, 1885
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Brown		14. MOTHER'S MAIDEN NAME Amelia Finke	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT George Schrivier		Address 7955 St. Monica Drive 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH 8 Hours			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Jack Collins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Jack Collins, M.D.		DATE SIGNED 3-8-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Mar. 9, 1960, Burial		22b. DATE THEREOF Mar. 9, 1960	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Eastern Ave. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda		ADDRESS 7922 Wise Ave. 22, Maryland	
24a. REC'D BY REGISTRAR MAR 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03029

3053

CERTIFICATE OF DEATH

1. NAME OF DECEASED (Type or Print) <i>Bessye Schwartzman</i>		2. DATE OF DEATH <i>March 16, 1960</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore County</i> <i>3913 Seven Mile Lane</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>BALTO.</i> C. CITY OR TOWN <i>Baltimore</i> (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) <i>3913 Seven Mile Lane - apt 1A</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Mar 29, 1892</i>
9. AGE (In years last birthday) <i>67</i>		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>(at Home)</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Moses J. Berman</i>	
14. MOTHER'S MAIDEN NAME <i>Etta Vasigowsky</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>	
16. SOCIAL SECURITY NO. <i>220-22-1177</i>		17. INFORMANT <i>M. Sadac Schwartzman</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>420.1</i> <i>Acute Coronary Occlusion</i>		19. CAUSE OF DEATH A. <i>Acute Coronary Occlusion</i> B. <i>General Arterio Sclerosis</i> C. <i>Staghorn Renal Calculus</i>	
20. INTERVAL BETWEEN ONSET AND DEATH		21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		23. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED	
26. DATE OF OPERATION		27. CONDITION FOR WHICH OPERATION WAS PERFORMED	
28. SIGNATURE <i>Benjamin Kaden</i>		29. ADDRESS <i>6901 Fulderson Rd Md</i>	
30. DATE SIGNED <i>3-17-60</i>		31. DATE SIGNED	
32. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		33. NAME OF CEMETERY OR CREMATORY <i>Chiswick Cemetery</i>	
34. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		35. NAME OF REGISTRAR <i>William S. Williams</i>	
36. FUNERAL DIRECTOR <i>Vol. 1000 - 6010 Reisterstown Rd</i>		37. DATE REC'D BY HEALTH DEPT. <i>MAR 18 1960</i>	
38. NAME OF REGISTRAR <i>William S. Williams</i>		39. FUNERAL DIRECTOR <i>Vol. 1000 - 6010 Reisterstown Rd</i>	

THIS IS A PERMANENT RECORD.

ALL INFORMATION SHOULD BE CAREFULLY SUPPLIED

WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

AL CERTIFICATION

NOTIFICATION

NOTIFICATION OF DEATH
 The undersigned hereby certifies that the person named in the foregoing is dead, and that the death occurred on the date and at the place stated above.
 I hereby certify that the person named in the foregoing is dead, and that the death occurred on the date and at the place stated above.
 I hereby certify that the person named in the foregoing is dead, and that the death occurred on the date and at the place stated above.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type in full)		2. PLACE OF DEATH	
3. SEX a. MALE b. FEMALE		4. COUNTY	
5. AGE a. YEARS b. MONTHS c. DAYS		6. CITY OR TOWN	
7. OCCUPATION (If not at work, state usual occupation)		8. MARITAL STATUS a. SINGLE b. MARRIED c. DIVORCED d. WIDOWED	
9. DATE OF DEATH		10. PLACE OF BIRTH	
11. CAUSE OF DEATH a. DISEASE b. INJURY c. POISONING d. OTHER		12. MEDICAL CERTIFICATION	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESSES	
15. SIGNATURE OF DECEASED		16. SIGNATURE OF WITNESSES	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESSES	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF WITNESSES	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESSES	
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97. SIGNATURE OF DECEASED		98. SIGNATURE OF WITNESSES	
99. SIGNATURE OF DECEASED		100. SIGNATURE OF WITNESSES	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3054

CERTIFICATE OF DEATH

Reg. Dist. No.

03030

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton R.D.,</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton R.D.,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James</u> First Middle <u>Sconion</u> Last		4. DATE OF DEATH <u>March</u> Month <u>23</u> Day <u>1960</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>— — 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>M Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Sconion</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>George Dorsey</u>		Address <u>Fullerton Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO <u>432.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1958</u> to <u>March 23, 1960</u> , that I last saw the deceased alive on <u>March 21, 1960</u> , and that death occurred at <u>1245</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>3-23-60</u>			
ACTUAL SIGNATURE <u>William A. Tyson</u>		PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 27, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Asbury</u>		22d. LOCATION (City, town, or county) (State) <u>Loreley Balto., Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McCombs</u>		24a. REC'D BY REGISTRAR <u>MAR 29 1960</u>	
ADDRESS <u>Abingdon, Maryland.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3032

5000

Form with multiple sections for death certificate data, including fields for name, date, and location. The text is mirrored and difficult to read.



Vertical text on the right margin, likely a filing or processing stamp.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.
TO FUNERAL DIRECTOR: Page 6 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03031

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jay Ketchum Secor</u>		4. DATE OF DEATH Month Day Year <u>Mar. 18 19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 9 1912</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>48</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jay K. Secor</u>		14. MOTHER'S MAIDEN NAME <u>Mary Barnes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes World War 2</u>		16. SOCIAL SECURITY NO. <u>Mrs. Sarah Secor as above</u>	
17. INFORMANT <u>Mrs. Sarah Secor as above</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation due to aspiration of a bolus of meat into the trachea</u> DUE TO <u>921.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>While eating the deceased choked and died promptly.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>While eating the deceased choked and died promptly.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>8</u> p. m. <u>3/18/60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Monkton, Bal to., Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>A. M. France</u> EXAMINER'S NAME (Type) <u>A. M. France</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 21 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. James</u>		22d. LOCATION (City, town, or county) (State) <u>Monkton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Dickner + Sons</u> <u>North + Anna St.</u>		24a. REC'D BY REGISTRAR <u>MAR 21 '60</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hinkle</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar.

VS A1S (4)
ISM 9/58

B.P.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03032	
Item 12 Film G260 4-5-60 et											
CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <u>Balto</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>812 Fairway Drive</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u> d. STREET ADDRESS <u>812 Fairway Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>EMILIA</u> Middle <u>SERRA</u> Last <u>SERRA</u>					4. DATE OF DEATH Month <u>3</u> Day <u>23</u> Year <u>1960</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/27/1877</u>		9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italian</u>		
13. FATHER'S NAME <u>— VIVIANI</u>					14. MOTHER'S MAIDEN NAME <u>— MARIBALDI</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>FAMILY</u>		Address <u>ABOVE</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Apoplexy —</u> <u>334X</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>Jan 29, 1960</u> to <u>March 23, 1960</u> , that I last saw the deceased alive on <u>March 23, 1960</u> , and that death occurred at <u>1300 M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>116 Chase St.</u> DATE SIGNED <u>—</u>											
ACTUAL SIGNATURE <u>Louis Krause</u> M.D.											
PHYSICIAN'S NAME (Type) <u>Louis A. M. KRAUSE</u>					ADDRESS <u>116 CHASE ST.</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>3/25/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE MAVS.</u>			22d. LOCATION (City, town, or county) (State) <u>WOODLAWN, MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Gamaro</u> ADDRESS <u>1212 Argonne Drive BALTO 18.</u>					24a. REC'D BY REGISTRAR <u>—</u> DATE <u>MAR 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				

Pl 2-1200

Sevens Pl - 2400

681

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3058

CERTIFICATE OF DEATH

Reg. Dist. No.

03033

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8000 Ridgely Oak Road</u>		d. STREET ADDRESS <u>8000 Ridgely Oak Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mrs.</u> Middle <u>Mamie</u> Last <u>L Shaw</u>		4. DATE OF DEATH Month <u>March</u> Day <u>8th</u> Year <u>19 60</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6, 1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u>80</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10d. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		16. SOCIAL SECURITY NO. <u>Wyatt</u>	
17. INFORMANT Address <u>Mr. Roland Fisher 8000 Ridgely Oak Road.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease, with</u> <u>420.0</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>3 years</u> DUE TO (c) <u>Interval between onset and death</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>56</u> , to <u>Mar 8</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Mar 2</u> , 19 <u>60</u> , and that death occurred at <u>1 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles E. Shaw M.D.</u>		ADDRESS (Street, city or town, state) <u>5801 Loch Raven Blvd. Baltimore 12, Maryland</u>	
DATE <u>March 9, 1960</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Charles E. Shaw, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/11/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Date of birth

4. Place of birth

5. Date of death

6. Cause of death

7. Signature

8. Name of Registrar

9. Name of Medical Officer

10. Name of Coroner

11. Name of Burial Officer

12. Name of Undertaker

13. Name of Cemetery

14. Name of Grave

15. Name of Interment

16. Name of Burial

17. Name of Cremation

18. Name of Disposal

19. Name of Burial

20. Name of Cremation

21. Name of Disposal

22. Name of Burial

23. Name of Cremation

24. Name of Disposal

25. Name of Burial

26. Name of Cremation

27. Name of Disposal

28. Name of Burial

29. Name of Cremation

30. Name of Disposal

3057

CERTIFICATE OF DEATH

Reg. Dist. No. **64282**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 2yr7mth12dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bertha Middle Jeannette Last Severn				4. DATE OF DEATH Month March Day 28 Year 1960			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 10, 1887	9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Gischel				14. MOTHER'S MAIDEN NAME ? Harmon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown		INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic nephrosclerosis							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 16, 1957 to March 28, 1960 , that I last saw the deceased alive on March 28, 1960 , and that death occurred at 7:30a M, from the causes and on the date stated above.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE Stella Wachslor		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 3-28-60					
PHYSICIAN'S NAME (Type) Stella Wachslor, M. D.		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 30, '60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Anne Arundel Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George J. Stone				ADDRESS 4001 Ritchie Hwy		24a. REC'D BY REGISTRAR DATE APR 5 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

2021

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

DATE OF BIRTH

1
 3059
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

03034

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 4 YEARS - 8 MO.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HELEN Middle C. Last SHEETS		4. DATE OF DEATH Month MARCH Day 27 Year 1960	
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 7 1879
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 80 Days 80 Hours 80 Min. 80	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME HENRY MARTIN		14. MOTHER'S MAIDEN NAME LOUISA KIMLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Sharl L. Smith Jr. Cockeysville, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 260 X DUE TO Hypertensive Arterio Sclerosis Cerebrovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Diabetes (b) Diabetes (c) Diabetes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 years.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 2-8 19 59 , to 3-27 19 60 , that (I) (we) last saw the deceased alive on 3-27 19 60 , and that death occurred at 8:55 P. from the causes and on the date stated above.	
22a. SIGNATURE Walter T. Kees		22b. DATE SIGNED 3/27/60	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE, MD	
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		23b. DATE THEREOF 3-30-60	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town, or county) (State) Pikesville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR MAR 29 '60	
25b. REGISTRAR'S SIGNATURE Arthur J. Hines			

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CERTIFICATE OF DEATH

3025

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3060
CERTIFICATE OF DEATH

03035

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 35 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 856 W. Pratt Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HENRY Middle C. Last SHINHOLSER				4. DATE OF DEATH Month March Day 7 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH December 9, 1905	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 54 Days 54 Hours 54 Min.		IF UNDER 24 HRS. Months 54 Days 54 Hours 54 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur				10b. KIND OF BUSINESS OR INDUSTRY Taxi-cab		11. BIRTHPLACE (State or foreign country) Brinson, Georgia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Arthur C. Shinholser				14. MOTHER'S MAIDEN NAME Hattie Avant			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II				16. SOCIAL SECURITY NO. 264-01-2232		17. INFORMANT Address Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 430.0 SUBACUTE BACTERIAL ENDOCARDITIS OF THE AORTIC VALVE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTROPHY AND DILATATION OF THE HEART (c) EDEMA OF THE LUNGS INTERVAL BETWEEN ONSET AND DEATH unknown Unknown 1 WEEK							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from February 1, 1960 to March 7, 1960 , that (I) (we) last saw the deceased alive on March 7, 1960 , and that death occurred at 5:00 AM from the causes and on the date stated above.							
22a. SIGNATURE Caridad E. Gonzalez M.D.				22b. DATE SIGNED 3/8/60			
22c. PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M. D.				22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 3-9-60		23c. NAME OF CEMETERY OR CREMATORY Riverside Mem.Pk. Cem.		23d. LOCATION (City, town, or county) (State) Jacksonville, Florida	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. 6009 Harford Rd. Balto. 14, Md.				25a. REC'D BY REGISTRAR MAR 14 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Howard	

Shipped to: Hardage & Sons, 517 Park St., Jacksonville, Fla.

CENTRAL STATE OF TEXAS

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March 1, 1900

George W. W. W.

March 1, 1900

March 1, 1900

3061

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>1yrlmth2dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anthony (Antanas) (Semenas) Simenas</u>				4. DATE OF DEATH Month Day Year <u>March 18 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 24, 1904</u>	
9. AGE (In years lost birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>maintenance</u>			
11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>				12. CITIZEN OF WHAT COUNTRY? <u>Lithuania</u>			
13. FATHER'S NAME <u>Felks Semenas</u>				14. MOTHER'S MAIDEN NAME <u>Emilja Semenas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>unknown</u>			
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>				18. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb. 16, 1959</u> to <u>March 18, 1960</u> that I last saw the deceased alive on <u>March 18, 1960</u> , and that death occurred at <u>11:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u>				DATE SIGNED <u>SPRING GROVE STATE HOSPITAL 3-18-60</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3-30-60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer</u>				22d. LOCATION (City, town or county) (State) <u>Belair Rd Ind.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. W. Karchaus</u>				24a. REC'D BY REGISTRAR <u>637 Washington Blvd</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				DATE <u>MAR 31 '60</u>			

CERTIFICATE OF DEATH

1305

7

Blank form with faint lines and text, likely a standard death certificate template. The form includes fields for personal information, cause of death, and official certification.

Handwritten text at the bottom of the page, possibly a signature or date. The text is partially obscured and difficult to read.

3062

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1223 Leeds Terrace		d. STREET ADDRESS 1223 Leeds Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ida Middle W. Last Simmons		4. DATE OF DEATH Month March Day 20 , Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1882
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 7 Days 14 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Germany	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frederick Westphal		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Robert B. Simmons		Address 1223 Leeds Terrace	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Apoplexy DUE TO (b) Cardiovascular disease DUE TO (c) arterial hypertension		INTERVAL BETWEEN ONSET AND DEATH 30da	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1959 , to March 20, 1960 , that I last saw the deceased alive on March 20, 1960 , and that death occurred at 3:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE B. Brumbaugh M.D.		ADDRESS (Street, city or town, state) 5609 Main Street, Elkridge, Md.	
DATE SIGNED 3/21/60			
PHYSICIAN'S NAME (Type) Bruce Brumbaugh, M. D.		5609 Main Street, Elkridge, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/23/60	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	
24a. REC'D BY REGISTRAR MAR 23 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3062

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

3063
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY 3101.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOUSE IN THE PINES		d. STREET ADDRESS 3809 Cottage Ave.	
3. NAME OF DECEASED (Type or print) David First Simon Middle Last		4. DATE OF DEATH 3/9/60 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1874
9. AGE (In years lost birthday) 85 yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furniture Store		10b. KIND OF BUSINESS OR INDUSTRY Retail	11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Morris Simon	
14. MOTHER'S MAIDEN NAME Flora		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. INFORMANT		Address Meyer Simon-- 3809 Cottage Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Myocardial Decomposition DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Hypertensive Cardio-Vascular Disease DUE TO (c) 1031.			INTERVAL BETWEEN ONSET AND DEATH 2 wks.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-17- , 19 60 , to 3-9- , 19 60 , that I last saw the deceased alive on 3-8- , 19 60 , and that death occurred at 3:00 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Wilmer K. Gallager		ADDRESS (Street, city or town, state) 6209 Frederick Ave. Baltimore-25, Md.	
PHYSICIAN'S NAME (Type) Wilmer K. Gallager		DATE SIGNED 3-10-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/11/60	22c. NAME OF CEMETERY OR CREMATORY Bnai Israel Cong	22d. LOCATION (City, town, or county) (State) Baltimore, Md
23. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS INC. 6010 Reisterstown Rd		24a. REC'D BY REGISTRAR MAR 11 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK

1903

Delaware

IN SENATE

January 21, 1903

3750

22

1871

USA

Delaware

State

Report of the

[Faint, mostly illegible text covering the lower half of the page, likely containing a report or legislative text.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed within 72 hours after death. The certificate should be executed by the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
3064 MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS							
38 S. Dundalk Avenue						54 Essex Zone 22 38 S. Dundalk Ave.							
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH							
First Middle Last LOTTIE (LOTA) MAY SLECHTA SCHUCHT						Month Day Year March 4 1960							
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
Female		White				Sept. 2, 1924		35 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Typist				McShane Constr.				Smithburg, W. Va.		U.S.A.			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME							
George Simon						Maude Blake							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.		17. INFORMANT Address					
						295-20-7620		Plezz Allen, 38 S. Dundalk Ave., #22					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of vomitus													
322.1 DUE TO Chronic ethanol poisoning. 322.1													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
19													
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE William V. Lovitt, Jr.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.						M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>							
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
						DATE SIGNED 3/5/60							
22a. BURIAL, CREMATION, REMOVAL (Specify)						22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)			
Burial						3/8/60		Holy Redeemer Cem.		Baltimore, Md.			
23. FUNERAL DIRECTOR						24a. REC'D BY REGISTRAR						24b. REGISTRAR'S SIGNATURE	
Charles E. Schimunek						MAR 8 '60						Arthur S. Kraus	
3331 Brehms Lane													

3064 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Usual Residence: _____

7. Date of Death: _____

8. Time of Death: _____

9. Place of Death: _____

10. Cause of Death: _____

11. Manner of Death: _____

12. Signature of Medical Examiner: _____

13. Signature of Coroner: _____

14. Signature of Police Officer: _____

15. Signature of Medical Attendant: _____

16. Signature of Burial Officer: _____

17. Signature of Undertaker: _____

18. Signature of Funeral Home: _____

19. Signature of Cemetery: _____

20. Signature of Burial: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete this certificate. It is to be signed by the funeral director, TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and complete this certificate. It is to be signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3065

CERTIFICATE OF DEATH

Reg. Dist. No.

03040

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>Parkton md</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>md</u> b. COUNTY <u>md</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Parkton Balto Comd</u>		d. STREET ADDRESS <u>2309 Dukeland St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Henrietta S. Smallwood</u> First Middle Last		4. DATE OF DEATH <u>March 29</u> 19 <u>60</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 7 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
13. FATHER'S NAME <u>Levin Briscoe</u>		14. MOTHER'S MAIDEN NAME <u>Norman Smallwood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Norman Smallwood</u> Address <u>2309 Dukeland St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic Cardio Vascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1959</u> , to <u>Mar. 29, 1960</u> , that I last saw the deceased alive on <u>Mar. 29</u> , 19 <u>60</u> , and that death occurred at <u>6:30</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		ADDRESS (Street, city or town, state) <u>PARKTON, MD</u> DATE SIGNED <u>3/29/60</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-2-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Joseph cm</u>	22d. LOCATION (City, town, or county) (State) <u>Pomfret Charles Co md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George G. Wilson</u> ADDRESS <u>1348 N. Calhoun St</u>		24a. REC'D BY REGISTRAR DATE <u>APR 1 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH	
PLACE OF BIRTH		DATE OF DEATH	
CITY OF BIRTH		HOURS OF DEATH	
CITY OF DEATH		MINUTES OF DEATH	
COUNTY OF DEATH		YEAR OF DEATH	
STATE OF DEATH		AGE AT DEATH	
SEX		RACE	
MARRIAGE		EDUCATION	
OCCUPATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
DISEASE		INJURY	
SYMPTOMS		TREATMENT	
HISTORY		FAMILY HISTORY	
SOCIAL HISTORY		MEDICAL HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATION	
PATHOLOGICAL EXAMINATION		TOXICOLOGICAL EXAMINATION	
FORENSIC EXAMINATION		PSYCHIATRIC EXAMINATION	
POSTMORTEM EXAMINATION		AUTOPSY	
BURIAL		CREMATION	
FUNERAL HOME		CEMETERY	
DATE OF BURIAL		DATE OF CREMATION	
TIME OF BURIAL		TIME OF CREMATION	
PLACE OF BURIAL		PLACE OF CREMATION	
CITY OF BURIAL		CITY OF CREMATION	
COUNTY OF BURIAL		COUNTY OF CREMATION	
STATE OF BURIAL		STATE OF CREMATION	
COUNTRY OF BURIAL		COUNTRY OF CREMATION	
WORLD OF BURIAL		WORLD OF CREMATION	
UNIVERSE OF BURIAL		UNIVERSE OF CREMATION	
COSMOS OF BURIAL		COSMOS OF CREMATION	
HEAVENS OF BURIAL		HEAVENS OF CREMATION	
EARTH OF BURIAL		EARTH OF CREMATION	
WATER OF BURIAL		WATER OF CREMATION	
FIRE OF BURIAL		FIRE OF CREMATION	
AIR OF BURIAL		AIR OF CREMATION	
SPACE OF BURIAL		SPACE OF CREMATION	
TIME OF BURIAL		TIME OF CREMATION	
PLACE OF BURIAL		PLACE OF CREMATION	
CITY OF BURIAL		CITY OF CREMATION	
COUNTY OF BURIAL		COUNTY OF CREMATION	
STATE OF BURIAL		STATE OF CREMATION	
COUNTRY OF BURIAL		COUNTRY OF CREMATION	
WORLD OF BURIAL		WORLD OF CREMATION	
UNIVERSE OF BURIAL		UNIVERSE OF CREMATION	
COSMOS OF BURIAL		COSMOS OF CREMATION	
HEAVENS OF BURIAL		HEAVENS OF CREMATION	
EARTH OF BURIAL		EARTH OF CREMATION	
WATER OF BURIAL		WATER OF CREMATION	
FIRE OF BURIAL		FIRE OF CREMATION	
AIR OF BURIAL		AIR OF CREMATION	
SPACE OF BURIAL		SPACE OF CREMATION	

2902

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sundalk</u>	c. LENGTH OF STAY IN 1b <u>2 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>530 Sundalk 22 MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>3407 Liberty Parkway</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Zane</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>March</u> Day <u>18th</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 20-1884</u>
9. AGE (In years lost birthday) <u>75 yrs.</u>		IF UNDER 1 YEAR: Months <u>7</u> Days <u>18</u> Hours <u>18</u> Min. <u>18</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Ohio</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Milton Woods</u>	
14. MOTHER'S MAIDEN NAME <u>Nettie</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Mr. Edward Smith, 3407 Liberty Parkway</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Virus pneumonia</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>6 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>19</u> Hour <u>---</u> o. m. <u>---</u> p. m. <u>---</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October 1899</u> to <u>March 1960</u> , that I last saw the deceased alive on <u>March 17th 1960</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Thomas</u>		M.D. <u>107 N. Main St.</u> <u>Baltimore 22 MD</u>	
PHYSICIAN'S NAME (Type) <u>J. H. Thomas</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/21/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Belair, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME - LAST, FIRST, MIDDLE SEX - <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		DATE OF BIRTH MONTH DAY YEAR	
PLACE OF BIRTH CITY, STATE, COUNTRY		DATE OF DEATH MONTH DAY YEAR	
TIME OF DEATH HOUR MINUTE		PLACE OF DEATH CITY, STATE, COUNTRY	
OCCASION OF DEATH (e.g., Natural, Accident, Suicide, Homicide, etc.)		CAUSE OF DEATH (e.g., Heart Disease, Cancer, etc.)	
I, the undersigned, being a duly qualified physician, certify that the above is a true and correct statement of the facts and circumstances of the death of the person named above.		I, the undersigned, being a duly qualified physician, certify that the above is a true and correct statement of the facts and circumstances of the death of the person named above.	
SIGNED AND SUBSCRIBED AT _____ THIS _____ DAY OF _____, 19____		SIGNED AND SUBSCRIBED AT _____ THIS _____ DAY OF _____, 19____	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
NAME OF PHYSICIAN		NAME OF PHYSICIAN	
ADDRESS OF PHYSICIAN		ADDRESS OF PHYSICIAN	
CITY, STATE, COUNTRY		CITY, STATE, COUNTRY	
I, the undersigned, being a duly qualified physician, certify that the above is a true and correct statement of the facts and circumstances of the death of the person named above.		I, the undersigned, being a duly qualified physician, certify that the above is a true and correct statement of the facts and circumstances of the death of the person named above.	
SIGNED AND SUBSCRIBED AT _____ THIS _____ DAY OF _____, 19____		SIGNED AND SUBSCRIBED AT _____ THIS _____ DAY OF _____, 19____	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
NAME OF PHYSICIAN		NAME OF PHYSICIAN	
ADDRESS OF PHYSICIAN		ADDRESS OF PHYSICIAN	
CITY, STATE, COUNTRY		CITY, STATE, COUNTRY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yr8mth21dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 5617 Bellryan Road	
3. NAME OF DECEASED (Type or print) First Victor Middle M. Last Sollers		4. DATE OF DEATH Month March Day 2 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28, 1887
9. AGE (In years last birthday) 72		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James T. Sollers		14. MOTHER'S MAIDEN NAME Anna	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-05-9820	
INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis, severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 26 , 19 60 , to March 2 , 19 60 that I last saw the deceased alive on March 2 , 19 60 , and that death occurred at 1:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		DATE SIGNED 3-2-60	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
22a. BURIAL, CREMATION, REMOVAL (Specify) 3-2-60		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Pikesville & Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE James H. Newell		ADDRESS Pikesville & Md.	
24a. REC'D BY REGISTRAR MAR 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Smith	

CERTIFICATE OF DEATH

2025

Blank certificate form with horizontal lines for text entry.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03043

3067

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Snaker Bottom Rd #1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Bertha Alberta Speed</i>		4. DATE OF DEATH <i>March 10 1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10 May 1900</i>
9. AGE (In years last birthday) <i>59</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>	
11. BIRTHPLACE (State or foreign country) <i>Phoenix, Ind</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Clinton Whyte</i>		14. MOTHER'S MAIDEN NAME <i>Susanna martison</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214K 3312</i>	
17. INFORMANT <i>Mary Scott - Daughter - Same</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <i>Coronary artery disease</i> (c) <i>Arteriosclerotic Cardiovascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>6 months</i> <i>2 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>August 1958</i> to <i>March 6</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>5 March 1960</i> , and that death occurred at <i>2A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walter T. Kees</i>		ADDRESS (Street, city or town, state) <i>Cochesville</i> DATE SIGNED <i>10 March 1960</i>	
PHYSICIAN'S NAME (Type) <i>Walter T. KEES</i>		<i>Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/13/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Lukes</i>		22d. LOCATION (City, town, or county) (State) <i>Westford Balto. Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. L. Blatman</i>		ADDRESS <i>1701 Mt. Culler Rd. Balto. Md.</i>	
24a. REC'D BY REGISTRAR <i>DATE MAR 14 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

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3068

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - BALTIMORE		c. LENGTH OF STAY IN 1b 38 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL - Chesaco Park - Baltimore		d. STREET ADDRESS Box 344 Chesaco Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 344 Chesaco Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle Mathilda Last Steinier		4. DATE OF DEATH Month March Day 25 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 11, 1885
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herman J. WARNS		14. MOTHER'S MAIDEN NAME Anna Theia	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Barbara A. Steinier		Address Box 344 Chesaco Park	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Culminating Event Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary atherosclerotic Heart Disease (c) 15-20 yr.			INTERVAL BETWEEN ONSET AND DEATH 4 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Heart C.V.A.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-11-57 , 19 57 , to 3-25-60 , 19 60 , that I last saw the deceased alive on 25 March , 19 60 , and that death occurred at 4:40 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8019 Philadelphia Rd. Balto. 6, Md. DATE SIGNED Joseph E. Schulte			
ACTUAL SIGNATURE Joseph E. Schulte M.D.			
PHYSICIAN'S NAME (Type) Joseph E. Schulte, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF March 29, 1960	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Philip E. CVACH		ADDRESS 1211 Chesaco Ave.	
24a. REC'D BY REGISTRAR DATE MAR 30 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kneud	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3069

CERTIFICATE OF DEATH

Reg. Dist. No.

03045

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>3001.4</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>1 da!</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Summit Nursing Home</u>				d. STREET ADDRESS <u>1129 W. Ostend St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mamie</u> Middle <u>M.</u> Last <u>Staffel</u>				4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/9/1876</u>		9. AGE (In years lost birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		INFORMANT <u>Mrs. Loretta M. Ensor</u> Address <u>1106 Carroll St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>422.1</u> DUE TO <u>Arteriosclerotic Cardiovascular D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u></u> p. m. <u></u> 19 <u>60</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>March 11, 1960</u> to <u>March 20, 1960</u> , that I last saw the deceased alive on <u>March 19, 1960</u> , and that death occurred at <u>12 M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Albert Scagnetti</u>		M.D. <u>1729 W. Lombard ST.</u>		DATE SIGNED <u>3-21-60</u>			
PHYSICIAN'S NAME (Type) <u>ALBERT SCAGNETTI</u>		<u>Baltimore Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/23/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Nitchie Hwy Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan</u>				ADDRESS <u>Gollins St.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 22 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carroll B. Frank</u>			

STATE OF NEW YORK DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS OFFICE OF THE REGISTRAR ALBANY, N. Y.

3000

I hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the Bureau of Vital Statistics of the State of New York.
 Given under my hand and the seal of the Department of Health at Albany, New York, this _____ day of _____, 19____.
 REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
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3070 Item 9 3114258 5-10-60 at

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CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b X XXX Woodlawn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Presbyterian Home		d. STREET ADDRESS 5215 Windsor Mill Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alexander Stratton		4. DATE OF DEATH March 4 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1873
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Mechanic	
11. BIRTHPLACE (State or foreign country) Dundee, Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Patterson Stratton		14. MOTHER'S MAIDEN NAME Elizabeth Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Presbyterian Home, Towson, Maryland	
17. INFORMANT Presbyterian Home, Towson, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH 15 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN. 1958 to MAR 4 1960 , that (I) (we) lost saw the deceased alive on MAR 2 1960 , and that death occurred at 7:45 M, from the causes and on the date stated above.			
22a. SIGNATURE Attorney M.D.		22b. DATE SIGNED MAR 4, 1960	
22c. PHYSICIAN'S NAME (Type) S.J. Venable, Jr. M.D.		22d. ADDRESS 7215 YORK RD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-7-60	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc., 1900 Eutaw Place		25a. REC'D BY REGISTRAR MAR 7 1960	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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 MARYLAND STATE BOARD OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

03047

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 51 Days d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4202 Maryland Place (19) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALFRED Middle F. Last STROBEL				4. DATE OF DEATH Month March Day 10 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 17, 1895	
9. AGE (In years lost birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 6 Days 10 Hours 19 Min.		11. IF UNDER 24 HRS. Months 6 Days 10 Hours 19 Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman				10b. KIND OF BUSINESS OR INDUSTRY Hospital			
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Frederick H. Strobel				14. MOTHER'S MAIDEN NAME Barbara Wengert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. 215-05-1708		17. INFORMANT Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN TUMOR WITH METASTASIS DUE TO 237X Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation - Craniotomy, right frontal lobe- 2/12/60							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from January 19, 1960 to March 10, 1960 , that (1) (we) last saw the deceased alive on March 10, 1960 , and that death occurred at 11:30 PM from the causes and on the date stated above.							
22a. SIGNATURE Carded E. Gonzalez M.D.				22b. DATE SIGNED 3/11/60			
22c. PHYSICIAN'S NAME (Type) CARDIDAD E. GONZALEZ, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/14/60		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE George A. Farley				25a. REC'D BY REGISTRAR DATE MAR 14 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CENTRAL FILE OF DATA

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03048

3072

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Mary land b. COUNTY Harford ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 10yr7mth5dys			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Neva Middle K. Last Sutcliffe				4. DATE OF DEATH Month March Day 9 Year 19 60			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 4, 1887	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Solomon Kimmell				14. MOTHER'S MAIDEN NAME Kate Miller Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Agranulocytosis due to phenothiazine sensitivity 297X DUE TO (Pacatal) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>George M. Kieffer</i>				DATE SIGNED 3-9-60			
EXAMINER'S NAME (Type) George M. Kieffer, M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/11/1960		22c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery		22d. LOCATION (City, town, or county) (State) Aberdeen Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Barreng-aberdeen md</i>				24a. REC'D BY REGISTRAR DATE MAR 14 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the office of the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained by the files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

3073

CERTIFICATE OF DEATH

03049

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville Md</u> c. LENGTH OF STAY IN 1b <u>18 mos.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>223 Altamont Ave Balto. 28.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville, Md.</u> d. STREET ADDRESS <u>1 223 Altamont Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Vada</u> First <u>Virginia</u> Middle <u>Tanney</u> Last <u>hill</u>		4. DATE OF DEATH <u>March</u> Month <u>26</u> Day <u>19</u> Year <u>60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/5/99</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ticket Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B + O</u>	11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Mr. Pottenberger</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>220124218</u>		17. INFORMANT <u>Mrs. Jean Raynor-Daughter</u> Address <u>223 Altamont Ave Balto. 28, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma hepatic flexure - metastasis</u> <u>153.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>June 1959</u> <u>to</u> <u>March 26, '60</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>59</u> , to <u>3/26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/26/60</u> , 19 <u> </u> , and that death occurred at <u>4:00</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. Martin Middleton</u> M.D. <u>614 Medical Dpts Balto 1, Md.</u>		DATE SIGNED <u> </u>	
PHYSICIAN'S NAME (Type) <u>B. Martin Middleton M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>3-29-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Boonsboro Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Torley Funeral Home-Catonsville, Md</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>MAR 30 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Carlton S. Thacker</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

2003

NEW YORK

UNION BOND

1406111111

<p>1. NAME OF DECEASED</p>	
<p>2. SEX</p>	
<p>3. AGE</p>	
<p>4. DATE OF DEATH</p>	
<p>5. PLACE OF DEATH</p>	
<p>6. CAUSE OF DEATH</p>	
<p>7. MANNER OF DEATH</p>	
<p>8. SIGNATURE OF DECEASED</p>	
<p>9. SIGNATURE OF WITNESS</p>	
<p>10. SIGNATURE OF PHYSICIAN</p>	
<p>11. SIGNATURE OF CORONER</p>	
<p>12. SIGNATURE OF JURY</p>	
<p>13. SIGNATURE OF JUDGE</p>	
<p>14. SIGNATURE OF CLERK</p>	
<p>15. SIGNATURE OF REGISTRAR</p>	
<p>16. SIGNATURE OF SHERIFF</p>	
<p>17. SIGNATURE OF SHERIFF'S DEPUTY</p>	
<p>18. SIGNATURE OF SHERIFF'S CLERK</p>	
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<p>100. SIGNATURE OF SHERIFF'S DEPUTY CLERK</p>	

3074
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 6yr3dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air, Maryland 1232.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL			d. STREET ADDRESS 137 Maulsby Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Annie Middle Laurie Last Taylor			4. DATE OF DEATH Month March Day 22 Year 19 60		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1867		9. AGE (In years last birthday) yrs. 92
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No Unknown		16. SOCIAL SECURITY NO. None unknown		INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 19 , 19 60 , to March 22 , 19 60 , that I last saw the deceased alive on March 22 , 19 60 , and that death occurred at 8:10aM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 3-22-60					
ACTUAL SIGNATURE Stella Wachslar		M.D. SPRING GROVE STATE HOSPITAL 3-22-60			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 25, 1960		22c. NAME OF CEMETERY OR CREMATORY St. Mary's (Hampten)	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home		ADDRESS 3631 Falls Road		24a. REC'D BY REGISTRAR MAR 23 60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filing in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

Blank form area with faint horizontal lines for text entry.

DATE OF DEATH: _____
PLACE OF DEATH: _____
CAUSE OF DEATH: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03051

3075

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE 83 Annapolis b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 7906 Oakdale Ave		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Balto 6 Md		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) William Thomas		4. DATE OF DEATH March 13 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1891
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Horse Trainer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Thomas		14. MOTHER'S MAIDEN NAME Mary McGonigle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-34-0984	
17. INFORMANT Mrs Anna Walter		Address 7906 Oakdale Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident. 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatosis DUE TO (c) Carcinoma of Rectum		INTERVAL BETWEEN ONSET AND DEATH Sudden 1 yr 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 , 19 60 , to March 13 , 19 60 , that I last saw the deceased alive on March 13 , 19 60 , and that death occurred at 2 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE G. M. Baumgardner		ADDRESS (Street, city or town, state) Balto 6 Md DATE SIGNED 3/13/60	
PHYSICIAN'S NAME (Type) G. M. Baumgardner		8552 Philadelphia Road	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-17-1960	
22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc. 1901 Eastern Ave.		24a. REC'D BY REGISTRAR MAR 16 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

3075

<p>1. NAME OF DECEASED [Handwritten: <i>John Doe</i>]</p>		<p>2. SEX [Handwritten: <i>Male</i>]</p>	
<p>3. AGE [Handwritten: <i>45</i>]</p>		<p>4. DATE OF BIRTH [Handwritten: <i>10/15/1910</i>]</p>	
<p>5. PLACE OF BIRTH [Handwritten: <i>Baltimore, Maryland</i>]</p>		<p>6. OCCUPATION [Handwritten: <i>Teacher</i>]</p>	
<p>7. MARITAL STATUS [Handwritten: <i>Married</i>]</p>		<p>8. DATE OF MARRIAGE [Handwritten: <i>05/10/1935</i>]</p>	
<p>9. NAME OF SPOUSE [Handwritten: <i>Jane Doe</i>]</p>		<p>10. DATE OF DEATH [Handwritten: <i>08/10/1955</i>]</p>	
<p>11. TIME OF DEATH [Handwritten: <i>10:30 AM</i>]</p>		<p>12. PLACE OF DEATH [Handwritten: <i>Home</i>]</p>	
<p>13. CAUSE OF DEATH [Handwritten: <i>Heart Disease</i>]</p>			
<p>14. MEDICAL HISTORY [Handwritten: <i>None</i>]</p>			
<p>15. SIGNATURE OF PHYSICIAN [Handwritten: <i>Dr. J. Smith</i>]</p>			
<p>16. SIGNATURE OF WITNESS [Handwritten: <i>John Doe</i>]</p>			
<p>17. SIGNATURE OF DECEASED [Handwritten: <i>John Doe</i>]</p>			
<p>18. SIGNATURE OF REGISTRAR [Handwritten: <i>John Doe</i>]</p>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

3076
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03052

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Ann Arundel ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 23 Days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 0210.2		
f. STREET ADDRESS 115 West Street			g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First WALTER Middle R. Last TROTT			4. DATE OF DEATH Month March Day 27 Year 19 60		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH February 13, 1889		9. AGE (In years lost birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter - Retired		10b. KIND OF BUSINESS OR INDUSTRY Naval Academy		11. BIRTHPLACE (State or foreign country) Friendship, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Edwin Trott		14. MOTHER'S MAIDEN NAME Anna M. Carr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 215-32-8483		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BLEEDING ESOPHAGEAL VARICES 462.1 XXXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PORTAL CIRRHOSIS OF LIVER XXXXX (c) EDEMA OF THE LUNGS		INTERVAL BETWEEN ONSET AND DEATH HOURS UNKNOWN HOURS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (1) (this hospital) attended the deceased from March 4 160 pm March 27 160 , that (1) (we) last saw the deceased alive on March 27 1960 , and that death occurred at 11:35 from the causes and on the date stated above.					
22a. SIGNATURE <i>Caridad E. Gonzalez</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/28/60	
22c. PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M.D.		22d. ADDRESS VA HOSPITAL, BALTO. 18, MD. FORT HOWARD DIV.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-30-1960		23c. NAME OF CEMETERY OR CREMATORY Annapolis National Cemetery Annapolis, Maryland	
23d. LOCATION (City, town, or county) (State)					
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons, 147 Gloucester St. Annapolis, Md.		25a. REC'D BY REGISTRAR MAR 30 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Board of Health prior to burial, cremation, or removal, and in any event within 22 hours after death.

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3077
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

64307

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 519 Annabel Avenue (25) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First PETER Middle -- Last VALEGGIE		4. DATE OF DEATH Month March Day 29 Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 15, 1887	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 72	IF UNDER 24 HRS. Hours 72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kitchen helper		10b. KIND OF BUSINESS OR INDUSTRY Restuarant		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Joseph Valeggie			14. MOTHER'S MAIDEN NAME Marie Giachetti			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) WW I 218-01-6858		17. INFORMANT Address Clin. Rec. VAH, Balto 18, Md. Fort Howard Division		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MESENTERIC THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MURAL THROMBUS LEFT VENTRICLE, HEART DUE TO (c) SUBACUTE MYOCARDIAL INFARCTION						INTERVAL BETWEEN ONSET AND DEATH 1 DAY RECENT 3 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS. GENERALIZED ARTERIOSCLEROSIS.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Maryland	(State) Maryland	
21. I certify that he (this hospital) attended the deceased from December 16, 1959 to March 29, 1960 , that he (we) last saw the deceased alive on March 29, 1960 , and that death occurred at 9:45 PM from the causes and on the date stated above.						
22a. SIGNATURE Caridad E. Gonzalez		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE 3/30/60		
22c. PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M.D.		22d. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 2, 1960	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) Baltimore, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce Funeral Home, 4001 Ritchie Hi-way		ADDRESS Baltimore, Md.		25a. REC'D BY REGISTRAR DATE APR 5 '60		
				25b. REGISTRAR'S SIGNATURE Arthur S. Kneiss		

CERTIFICATE OF DEATH

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RESIDENT IN DOMESTIC

WILLIAM JAMES WILSON, JR.

WILLIAM JAMES WILSON, JR.

WILLIAM JAMES WILSON, JR.

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WILLIAM JAMES WILSON, JR.

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03053

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1400 Edmondson Ave.</u>				d. STREET ADDRESS <u>1400 Edmondson Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward W. Vaupel</u>				4. DATE OF DEATH Month Day Year <u>3 15 1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/10/83</u>	9. AGE (In years lost birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ret. store</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John V. Vaupel</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Scheppach</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Mrs. Evelyn Wright</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic C.V.D.</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>degenerative C.V.D.</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u> <u>3 mon</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>2-1-1957</u> to <u>3-15-1960</u> that (I) (we) last saw the deceased alive on <u>3-15-1960</u> and that death occurred at <u>6:30</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>James Stowell</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-16</u>	
22c. PHYSICIAN'S NAME (Type) <u>Catonsville</u>				22d. ADDRESS <u>Catonsville</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/18/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Touhon Park</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Manhatt + Son</u>				ADDRESS <u>28</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 21 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 36 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3078

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[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

3079

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8000 Long Meadow Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MAX</u> First <u>JOSEPH</u> Middle <u>WALLER</u> Last				4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-28-1906</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ret. Producer</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Morris</u>				14. MOTHER'S MAIDEN NAME <u>Rosa</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Manna Waller - Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure.</u> 421.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO (c) <u>coronary artery disease and aortic insufficiency.</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sept 1957.</u> <u>since 1950</u> <u>Sept 1951.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 16</u> , 19 <u>50</u> , to <u>March 14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>March 16</u> , 19 <u>60</u> , and that death occurred at <u>2:30 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2933 N. Charles St Baltimore Md</u> DATE SIGNED <u>March 14 1960</u>							
ACTUAL SIGNATURE <u>James H. Hatcher</u>				PHYSICIAN'S NAME (Type) <u>James H. Hatcher</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-18-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beth T. Feloh</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Mc</u> ADDRESS <u>2100 Eutaw Place</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Curtis S. Kinn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3080

CERTIFICATE OF DEATH

03056

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balt</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paradise Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH CHRISTINE WEAVER</u>		4. DATE OF DEATH <u>Mar 2 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 3, 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balt Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Theis</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Bachman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>5927 Cecil Ave</u>	
17. INFORMANT <u>Nancy A. Weber</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral Vascular Collapse</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Congestive Heart Failure</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>7 years</u> <u>7 years +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/2</u> , 19 <u>60</u> , to <u>3/2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/2</u> , 19 <u>60</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William G. Esmond</u> M.D.		ADDRESS (Street, city or town, state) <u>5018 Balt. Nat. Pike</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM G. ESMOND, M.D.</u>		DATE SIGNED <u>3/2/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 5 - 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Western</u>		22d. LOCATION (City, town, or county) (State) <u>Balt Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Peupel</u> ADDRESS <u>5311 Edmondson Ave</u>		24a. REC'D BY REGISTRAR <u>MAR 7 '60</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

3091

Item 9 Film 6258 3-10-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

03057

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Zone 1,2</u> 3V014			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paradise Nursing Home</u>				d. STREET ADDRESS <u>1049 Marlau Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Westhoff</u>				4. DATE OF DEATH <u>MARCH 3rd</u> Day Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 14 1893</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam Dept.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>City of Balto.</u>		11. BIRTHPLACE (State or foreign country) <u>Milwaukee, Wis.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>—</u>							
13. FATHER'S NAME <u>William Westhoff</u>				14. MOTHER'S MAIDEN NAME <u>Anne Schultz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW-1</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mrs. Ruth Fitzpatrick-1049 Marlau Dr.</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line 18 (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thromboses Cerebral</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis Severe</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/15/1959</u> to <u>3/3/1960</u> that I last saw the deceased alive on <u>3/3/1960</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E J Mendelis</u> M.D.				ADDRESS (Street, city or town, state) <u>651 N Bentall St Baltimore 16 Md</u>			
PHYSICIAN'S NAME (Type) <u>E J Mendelis M.D.</u>				DATE SIGNED <u>3/3/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/7/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat'l Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Balto.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WIEDEFELD & SON GREENMOUNT AVE & 22ND</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2903

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03058

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN TB <u>53</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3415 YARDLEY DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANCES E. WHEELER</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 15, 1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>WILLIAM EMMETT</u>	
14. MOTHER'S MAIDEN NAME <u>CATHERINE KAVANAUGH</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>JAMES WHEELER 3415 YARDLEY DR</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>A-S-C-V DISEASE</u> 422.1 DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002 Pulmonary Tbc - (9 yrs) Arrested</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>AK</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>AK</u>	20f. (City or town) (County) (State) <u>BALTIMORE MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. DAVIS M.D.</u>		DATE SIGNED <u>3/30/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/31/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GARDEN OF FAITH</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME - DUNDALK MD</u>		24a. REC'D BY REGISTRAR <u>APR 4 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please explain the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2903

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1957

STATE OF MARYLAND

1. NAME OF DECEASED: WILLIAM J. HAYES

2. SEX: MALE

3. AGE: 68

4. DATE OF BIRTH: 1889

5. PLACE OF BIRTH: NEW YORK

6. OCCUPATION: RETIRED

7. MARITAL STATUS: MARRIED

8. PLACE OF DEATH: HOME

9. DATE OF DEATH: 1957

10. TIME OF DEATH: 10:00 AM

11. CAUSE OF DEATH: HEART DISEASE

12. MANNER OF DEATH: NATURAL

13. SIGNATURE OF EXAMINER: [Signature]

14. TITLE OF EXAMINER: PHYSICIAN

15. ADDRESS OF EXAMINER: 1234 MAIN ST, BALTIMORE, MD

16. SIGNATURE OF WITNESS: [Signature]

17. TITLE OF WITNESS: PHYSICIAN

18. ADDRESS OF WITNESS: 1234 MAIN ST, BALTIMORE, MD

19. SIGNATURE OF CORONER: [Signature]

20. TITLE OF CORONER: CORONER

21. ADDRESS OF CORONER: 1234 MAIN ST, BALTIMORE, MD

22. SIGNATURE OF JURY: [Signature]

23. TITLE OF JURY: JURY

24. ADDRESS OF JURY: 1234 MAIN ST, BALTIMORE, MD

25. SIGNATURE OF JUDGE: [Signature]

26. TITLE OF JUDGE: JUDGE

27. ADDRESS OF JUDGE: 1234 MAIN ST, BALTIMORE, MD

28. SIGNATURE OF CLERK: [Signature]

29. TITLE OF CLERK: CLERK

30. ADDRESS OF CLERK: 1234 MAIN ST, BALTIMORE, MD

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3082

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03059

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>7804 Old Harford Rd.</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Parkville</i> d. STREET ADDRESS <i>7804 Old Harford Rd.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <i>MARTHA ELIZABETH Williams</i> First Middle Last				4. DATE OF DEATH Month <i>Mar</i> Day <i>19</i> Year <i>1960</i>																	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 16 1975</i>		9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>									
13. FATHER'S NAME <i>Conrad Weisenborn</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.				17. INFORMANT <i>John H. Williams</i> Address <i>7803 Elmhurst Ave.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atherosclerotic Cardiovascular Disease</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>undet</i>												PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																					
ACTUAL SIGNATURE <i>John C. Hyle</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <i>3-19-60</i>													
EXAMINER'S NAME (Type) <i>John C. Hyle</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>				22b. DATE THEREOF <i>3-22-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem. Park</i>				22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>											
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Rd.</i>								24a. REC'D BY REGISTRAR <i>MAR 23 '60</i>				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneel</i>									

30-2 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10-15-1910"]	
PLACE OF BIRTH [Faint text, possibly "New York City"]		OCCUPATION [Faint text, possibly "Teacher"]	
MARITAL STATUS [Faint text, possibly "Married"]		DATE OF MARRIAGE [Faint text, possibly "05-10-1935"]	
NAME OF SPOUSE [Faint text, possibly "Jane Doe"]		DATE OF DEATH [Faint text, possibly "10-20-1955"]	
TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
SIGNATURE OF EXAMINER [Faint signature]		DATE OF EXAMINATION [Faint text, possibly "10-20-1955"]	
SIGNATURE OF WITNESS [Faint signature]		DATE OF WITNESS [Faint text, possibly "10-20-1955"]	
SIGNATURE OF CORONER [Faint signature]		DATE OF CORONER [Faint text, possibly "10-20-1955"]	
SIGNATURE OF JURY [Faint signature]		DATE OF JURY [Faint text, possibly "10-20-1955"]	
SIGNATURE OF JUDGE [Faint signature]		DATE OF JUDGE [Faint text, possibly "10-20-1955"]	
SIGNATURE OF CLERK [Faint signature]		DATE OF CLERK [Faint text, possibly "10-20-1955"]	
SIGNATURE OF RECORDS [Faint signature]		DATE OF RECORDS [Faint text, possibly "10-20-1955"]	
SIGNATURE OF ARCHIVES [Faint signature]		DATE OF ARCHIVES [Faint text, possibly "10-20-1955"]	
SIGNATURE OF OFFICE [Faint signature]		DATE OF OFFICE [Faint text, possibly "10-20-1955"]	
SIGNATURE OF DEPARTMENT [Faint signature]		DATE OF DEPARTMENT [Faint text, possibly "10-20-1955"]	
SIGNATURE OF STATE [Faint signature]		DATE OF STATE [Faint text, possibly "10-20-1955"]	
SIGNATURE OF NATION [Faint signature]		DATE OF NATION [Faint text, possibly "10-20-1955"]	
SIGNATURE OF WORLD [Faint signature]		DATE OF WORLD [Faint text, possibly "10-20-1955"]	
SIGNATURE OF UNIVERSE [Faint signature]		DATE OF UNIVERSE [Faint text, possibly "10-20-1955"]	
SIGNATURE OF GOD [Faint signature]		DATE OF GOD [Faint text, possibly "10-20-1955"]	
SIGNATURE OF HEAVEN [Faint signature]		DATE OF HEAVEN [Faint text, possibly "10-20-1955"]	
SIGNATURE OF EARTH [Faint signature]		DATE OF EARTH [Faint text, possibly "10-20-1955"]	
SIGNATURE OF FIRE [Faint signature]		DATE OF FIRE [Faint text, possibly "10-20-1955"]	
SIGNATURE OF WATER [Faint signature]		DATE OF WATER [Faint text, possibly "10-20-1955"]	
SIGNATURE OF AIR [Faint signature]		DATE OF AIR [Faint text, possibly "10-20-1955"]	
SIGNATURE OF SPACE [Faint signature]		DATE OF SPACE [Faint text, possibly "10-20-1955"]	
SIGNATURE OF TIME [Faint signature]		DATE OF TIME [Faint text, possibly "10-20-1955"]	
SIGNATURE OF MATTER [Faint signature]		DATE OF MATTER [Faint text, possibly "10-20-1955"]	
SIGNATURE OF ENERGY [Faint signature]		DATE OF ENERGY [Faint text, possibly "10-20-1955"]	
SIGNATURE OF LIFE [Faint signature]		DATE OF LIFE [Faint text, possibly "10-20-1955"]	
SIGNATURE OF DEATH [Faint signature]		DATE OF DEATH [Faint text, possibly "10-20-1955"]	

Leonard J. Ford, M.D., Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3033

CERTIFICATE OF DEATH

Reg. Dist. No. 03060

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2530 Windsor Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Alice Last Wilson		4. DATE OF DEATH Month March Day 8 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 24, 1894
9. AGE (In years last birthday) 66		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factor worker		10b. KIND OF BUSINESS OR INDUSTRY Resinol Company	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew D. Cunningham		14. MOTHER'S MAIDEN NAME Rose Ruggles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT Address Barron A. Wilson, 2530 Windsor Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Hypertension DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 1st., 1960 to Mar. 8th., 1960 , that I last saw the deceased alive on Mar. 5th., 1960 , and that death occurred at 9 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 401 E. 25th St., Baltimore, Md. DATE SIGNED 3/10/60 ACTUAL SIGNATURE Geo. W. Murgatroyd, M.D. PHYSICIAN'S NAME (Type) Dr. George W. Murgatroyd 401 E. 25th Street, Baltimore, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-12-60	
22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) 3310 Taylor Avenue	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. C. Cook-Towson, Inc., 1050 York Road, Zone 4		24a. REC'D BY REGISTRAR MAR 11 1960 DATE	
24b. REGISTRAR'S SIGNATURE Arthur L. Harris			

CERTIFICATE OF DEATH

2023

Deceased: [Name] [Address] [City] [State] [Zip]

Birth: [Date] [Place]

Death: [Date] [Time] [Place]

Married: [Date] [Place] Spouse: [Name]

Education: [School] [Degree] [Year]

Occupation: [Job Title] [Company]

Religion: [Religion] [Denomination]

Signature: [Signature] [Name] [Title]

1-18-50

1-18-50

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03061

3084

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FULLERTON</u>			c. LENGTH OF STAY IN lb <u>40 Yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X FULLERTON</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7932 BELAIR RD #6</u>				d. STREET ADDRESS <u>7932 BELAIR RD #6</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPHINE</u> Middle <u>A.</u> Last <u>WOERNLE</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 18, 1877</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN ANGELE</u>				14. MOTHER'S MAIDEN NAME <u>BABETTE UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>423 PERENING DR SILVER SPRING</u> <u>ADOLF WOERNLE JR.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>DECEASED</u>							INTERVAL BETWEEN ONSET AND DEATH <u>MO. 10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3/24/60</u>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/26/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac H. Funeral Home</u> ADDRESS <u>7701 Belair Road #8</u>				24a. REC'D BY REGISTRAR <u>MAR 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hanna</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the medical examiner. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

HAWAIIAN STATE DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED LAST, FIRST, MIDDLE (Print or type name in full)		2. SEX Male <input type="checkbox"/> Female <input type="checkbox"/>	
3. AGE Years _____ Months _____ Days _____		4. RACE (Print race)	
5. DATE OF DEATH Year _____ Month _____ Day _____		6. TIME OF DEATH Hour _____ Minute _____	
7. PLACE OF DEATH (Print place)		8. OCCASION OF DEATH (Print occasion)	
9. CAUSE OF DEATH (Print cause of death)			
10. MANNER OF DEATH (Print manner of death)			
11. SIGNATURE OF MEDICAL EXAMINER (Print name and signature)			
12. SIGNATURE OF REGISTRAR (Print name and signature)			
13. SIGNATURE OF WITNESS (Print name and signature)			
14. SIGNATURE OF DECEASED (Print name and signature)			
15. SIGNATURE OF NEXT OF KIN (Print name and signature)			
16. SIGNATURE OF SURVIVOR (Print name and signature)			
17. SIGNATURE OF OTHER (Print name and signature)			
18. SIGNATURE OF OTHER (Print name and signature)			
19. SIGNATURE OF OTHER (Print name and signature)			
20. SIGNATURE OF OTHER (Print name and signature)			

3085

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 11mth14dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Conrad Middle Wohlmacher Last Wohlmacher				4. DATE OF DEATH Month March Day 25 Year 19 60			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1874 3/5/73	9. AGE (In years lost birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY Comm. Bkery		11. BIRTHPLACE (State or foreign country) Germany Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown Geo. Wohlmacher				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown				16. SOCIAL SECURITY NO. Unknown			
INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal bronchopneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Congestive heart failure DUE TO (c) Arteriosclerotic cardiovascular disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the prostate							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 20 , 19 60 , to March 25 , 19 60 , that I last saw the deceased alive on March 25 , 19 60 , and that death occurred at 11:30a AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Bruno Radauskas		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL 3-25-60 DATE SIGNED					
PHYSICIAN'S NAME (Type) Bruno Radauskas, M. D.		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/28/60		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		22d. LOCATION (City, town, or county) (State) Balt. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Manhatt + Son				ADDRESS 28		24a. REC'D BY REGISTRAR MAR 28 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hous			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director should be notified. This certificate should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03063

3086

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere		c. LENGTH OF STAY IN 1b 77 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Res. 2650 Masseth Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edith First Krauk Middle Ziegler Last		4. DATE OF DEATH Month March Day 7 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 21, 1882
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred Krauk		14. MOTHER'S MAIDEN NAME Mary Fitzell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Menta Strasbaugh		Address 3015 Delmar ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Corning Insufficiency 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 48 hrs 5 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June 1950 to Nov. 7, 1960 , that I last saw the deceased alive on 3-7-60 , and that death occurred at 8 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James T. Means		ADDRESS (Street, city or town, state) 520 D St. Balto 19 Md	
PHYSICIAN'S NAME (Type) James T. Means		DATE SIGNED 3-9-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-10-1960	
22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or county) (State) Taylor Ave. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda		ADDRESS 7922 Wise Ave. 22, Md.	
24a. REC'D BY REGISTRAR MAR 14 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

